

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
1300 Pennsylvania Avenue, NW  
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Thursday, September 7, 2023  
10:49 a.m.

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AGENDA	PAGE
Context for Medicare payment policy	
- Rachel Burton.....	5
Lunch.....	46
Medicare Advantage: MedPAC workplan	
- Andy Johnson, Stuart Hammond, Katelyn Smalley.....	48
Recess.....	81
Standardized benefits in Medicare Advantage plans	
- Eric Rollins.....	82
Recess.....	152
Improving MedPAC's estimate of Medicare Advantage coding intensity	
- Andy Johnson.....	153
Adjourn.....	211

P R O C E E D I N G S

[10:49 a.m.]

1  
2  
3 DR. CHERNEW: Hello, everybody, and welcome to  
4 our first meeting of the 2023-2024 MedPAC cycle. We think  
5 it's going to be an important and, as always, interesting  
6 and productive cycle. We have a lot of important things on  
7 the agenda.

8 But before I start, it's important to acknowledge  
9 that we have a big change. Some of you who follow MedPAC  
10 may know that our Executive Director, Jim Matthews,  
11 resigned. Jim had very big shoes to fill. It turns out  
12 there was only one person whose feet were big enough to  
13 fill those shoes, and that turns out to be Paul Masi, who  
14 is the new Executive Director. Apart from being a  
15 wonderful person, which is a prerequisite for the job, he  
16 also has a lot of experience with MedPAC. He was the  
17 Assistant Director for three years before he took the job  
18 that he had immediately preceding this, which was the Chief  
19 of the Medicare Cost Estimates Unit at CBO.

20 So, Paul, we are thrilled to have you, and  
21 welcome.

22 MR. MASI: Thank you so much, Mike. I really

1 appreciate that.

2           And I'll keep this short because I know we have a  
3 lot of important work to get to. I'm grateful to you and  
4 the Commission for this opportunity. Leading the staff at  
5 MedPAC is a real honor, and I also want to thank Jim  
6 Mathews for his many years of dedicated service to the  
7 Commission.

8           Returning to MedPAC is a real thrill. As Mike  
9 said, I worked here from 2017 through 2019 as the Assistant  
10 Director, and during that time, I developed a deep  
11 appreciation for MedPAC the institution, its mission, and  
12 our work.

13           I want to emphasize continuity. So MedPAC will  
14 remain focused on its mission of serving the Congress with  
15 analysis and advice and committed to our principles of  
16 making Medicare better for beneficiaries, taxpayers, and  
17 providers.

18           Let's get to work.

19           DR. CHERNEW: And in this case, work entails a  
20 discussion of the context for Medicare payment policy.  
21 Every year in the March report, we publish a chapter that  
22 just discusses broad issues related to the Medicare

1 program, and so we're going to review that chapter now.  
2 And the person who really deserves all the credit is  
3 Rachel.

4 So, Rachel, I'm turning it over to you.

5 MS. BURTON: Good morning. I'm thrilled to be  
6 the first to use our fabulous new slide template redesigned  
7 by our own Tina Jennings and hope you all like our new look  
8 as much as I do.

9 In this presentation, I'll provide some  
10 contextual information meant to serve as a backdrop for  
11 Commissioner discussions over the coming cycle. This  
12 information will be included in our March report to the  
13 Congress along with our annual payment update  
14 recommendations.

15 For those watching online, a PDF of these slides  
16 is available from the webinar's control panel on the right  
17 side of your screen.

18 In this presentation, I'll touch on recent  
19 spending trends, factors that are expected to influence  
20 Medicare spending in the coming decade, and the financial  
21 status of Medicare's two trust funds. I'll also give a  
22 sense of how affordable current premiums and cost sharing

1 are for beneficiaries.

2           This graph shows health care spending as a share  
3 of GDP. During the recent coronavirus pandemic, national  
4 health care spending as a share of GDP, shown by the upper  
5 line, sharply increased in 2020 as the federal government  
6 paid out hundreds of billions of dollars in relief funds to  
7 health care providers at a time when GDP was shrinking.  
8 National health care spending as a share of GDP then began  
9 shrinking in 2021 as federal relief funds tapered off and  
10 GDP grew rapidly.

11           In 2023, national health care spending as a share  
12 of GDP is expected to have returned to its pre-pandemic  
13 level of 17.6 percent.

14           Meanwhile, Medicare spending as a share of GDP,  
15 shown by the lower line, has grown at a slower-than-usual  
16 pace during the pandemic. Although spending increased on  
17 COVID-19 testing and treatment and on services that were  
18 made more widely available through waivers of Medicare's  
19 usual payment rules, this increase was more than offset by  
20 decreased spending on non-COVID care.

21           Looking ahead to future years, shown to the right  
22 of the vertical line, CMS expects both national health care

1 spending and Medicare spending to grow faster than GDP,  
2 causing them to constitute a growing share of GDP in coming  
3 years.

4 CMS expects Medicare spending to grow by 7 to 8  
5 percent per year on average between now and 2031. This  
6 will result in Medicare spending doubling over a 10-year  
7 period, rising from over \$900 billion in 2022 to \$1.8  
8 trillion in 2031.

9 Medicare's projected spending growth for Part A  
10 and Part B services is driven by three factors: economy-  
11 wide price increases, growth in the number of Medicare  
12 beneficiaries as the baby-boom generation ages into the  
13 program, and growth in the volume and intensity of services  
14 delivered per beneficiary which I'll talk more about on the  
15 next slide.

16 An increasing volume of services refers to  
17 providers delivering more services per beneficiary over  
18 time. An increasing intensity of services can occur when  
19 providers use more expensive options instead of less  
20 expensive options. For example, as shown in this graph,  
21 clinicians treating fee-for-service beneficiaries have been  
22 billing more office visits using the 99214 billing code,

1 which involves a moderate level of medical decision-making  
2 and fewer office visits using the lower-priced 99213 code,  
3 which involves a low level of medical decision-making.

4           Switching gears, I'll now talk about Medicare's  
5 two trust funds. The first of these and the one that  
6 people normally talk about is the Hospital Insurance Trust  
7 Fund, which finances Part A services, such as inpatient  
8 hospital stays and post-acute care afterward. This trust  
9 fund currently finds itself in a better financial position  
10 than before the pandemic.

11           After an initial economic slowdown in 2020, the  
12 U.S. economy experienced strong growth in 2021 and 2022,  
13 yielding higher-than-expected Medicare payroll tax  
14 revenues, which are the main source of funding for this  
15 trust fund. These higher-than-expected revenues are  
16 projected to continue in coming years.

17           At the same time, CMS now projects that Part A  
18 spending will be lower than previously expected. Some of  
19 the drivers of this trend are the fact that the  
20 beneficiaries who survived the pandemic have lower average  
21 morbidity. In addition, some hip and knee replacements  
22 have shifted to outpatient settings after their recent



1 removal from Medicare's inpatient-only list. As a result,  
2 the account balance in this trust fund has been increasing  
3 and is now projected to have sufficient funds to pay its  
4 share of Part A services until sometime in 2031, according  
5 to the Medicare trustees, or sometime after 2033, according  
6 to CBO, which is several more years than was projected  
7 before the pandemic.

8           Despite this reprieve, the Hospital Insurance  
9 Trust Fund still faces a fundamental financing problem,  
10 since the ratio of workers to Medicare beneficiaries has  
11 been declining since the program began and is expected to  
12 continue to do so.

13           Around the time of Medicare's inception, there  
14 were four and a half workers for each Medicare beneficiary,  
15 but by 2022, there were only 2.9 workers per beneficiary.  
16 And by 2031, there are expected to be only 2.5 workers per  
17 beneficiary.

18           There are a few ways to extend the solvency of  
19 this trust fund. Two that are mentioned by Medicare's  
20 trustees are to increase the Medicare payroll tax rate from  
21 2.9 percent to 3.6 percent or to decrease Medicare Part A  
22 spending by 15.6 percent, which would be equivalent to a

1 reduction of \$65 billion in 2024 that would then need to be  
2 maintained in subsequent years. Either of these approaches  
3 or some more moderate combination of them could extend the  
4 solvency of the trust fund for an additional 25 years.

5 Medicare's other trust fund is called the  
6 Supplementary Medical Insurance Trust Fund. It helps pay  
7 for Part B clinician and outpatient services and Part D  
8 prescription drug coverage. This trust fund works  
9 differently than the Hospital Insurance Trust Fund, since  
10 it automatically remains solvent through transfers from the  
11 federal government's general revenues and beneficiary  
12 premiums that are re-priced each year. Over time, a  
13 growing share of federal revenues, which mainly consists of  
14 personal and corporate income taxes, are expected to be  
15 needed to finance this trust fund.

16 For example, in 2022, 13 percent of all personal  
17 and corporate income taxes were transferred to this trust  
18 fund to pay for Part B and Part D, but by 2030, 22 percent  
19 of all income tax revenues are expected to be needed for  
20 this purpose. As more federal revenues are used to pay for  
21 Medicare, it leaves less room in the federal budget for  
22 other purposes. When premiums and cost sharing go up, it

1 also leaves less room in beneficiaries' household budgets.

2           The typical Medicare beneficiary has relatively  
3 modest resources to draw on when paying for premiums and  
4 cost sharing. Researchers estimate that the median  
5 Medicare beneficiary had an annual income in 2019 of about  
6 \$30,000 and life savings of about \$74,000. Medicare  
7 beneficiaries typically do not pay premiums for Part A, but  
8 the annual cost of Part B premiums is about \$2,000 in 2023,  
9 and the average annual cost of Part D premiums is about  
10 \$500.

11           In addition, cost sharing for beneficiaries in  
12 traditional fee-for-service Medicare averaged about \$400  
13 for Part A services in 2021, about \$1,600 for Part B  
14 services, and about \$450 for beneficiaries with Part D drug  
15 coverage. One thing to note here is that beneficiaries'  
16 average Part D cost sharing is likely to decline in future  
17 years due to new limits on cost sharing that were included  
18 in the Inflation Reduction Act of 2022.

19           As shown at left, about 8 percent of Medicare  
20 beneficiaries report trouble getting health care due to  
21 cost, but some subgroups, shown at right, report this at  
22 even higher rates. Among beneficiaries under the age of 65

1 who are either disabled or have end-stage renal disease, 20  
2 percent report problems getting care due to cost. Among  
3 beneficiaries with fee-for-service and no supplemental  
4 coverage and among partial-benefit dual-eligible  
5 beneficiaries, 15 percent of each of these groups report  
6 this difficulty. All of this is to say when Medicare  
7 increases payment rates for providers, it also increases  
8 premiums and cost sharing for Medicare beneficiaries, some  
9 of whom already have a hard time affording care.

10           With that, I'll wrap up. In your discussion,  
11 I'll be looking to see if anything in the chapter needs to  
12 be clarified or if you have any other questions, comments,  
13 or guidance as we finalize the chapter for the March  
14 report. As usual, the draft chapter Commissioners received  
15 for today's meeting will be updated in the winter when some  
16 newer data become available. Commissioners will have an  
17 opportunity to review a revised version of the chapter in  
18 January.

19           I'll now turn things back over to Mike.

20           DR. CHERNEW: Rachel, thank you. That's always  
21 an information-packed chapter. A lot of people tell me  
22 they like to read it. So that's really outstanding.

1 I am going to go to the queue, and I think we are  
2 going to start with Jonathan.

3 Are you going to be running the queue? Dana is  
4 coming back.

5 So we're going to go with Jonathan, and after  
6 Jonathan, we're going to have Cheryl and Betty, and then  
7 we'll be back on track.

8 DR. JAFFERY: Great. Thanks, Mike, and thanks,  
9 Rachel. Yeah, as always, it's a great chapter. Even after  
10 six years, I keep learning tons.

11 So my question, my Round 1 question, is in the  
12 reading at the bottom, the paragraph at the bottom of page  
13 28, top of 29, it talks about beneficiary out-of-pocket  
14 spending and the supplemental ways that they cover that  
15 sometimes, and the last sentence of the paragraph, which is  
16 at the top of page 29, says that it leaves only 9 percent  
17 of beneficiaries in fee-for-service Medicare without any  
18 supplemental coverage. If you look at the figure just  
19 below it, it looks like that's 9 percent of all Medicare  
20 beneficiaries. Is that correct?

21 MS. BURTON: That was my intended meaning. It  
22 sounds like I need to tweak the wording of the sentence.

1 DR. JAFFERY: Yeah, yeah. Okay. Just wanted to  
2 clarify. Perfect. Thank you.

3 MS. KELLEY: Cheryl?

4 DR. DAMBERG: Thanks. This was a great chapter,  
5 and you did a fabulous job of presenting a ton of  
6 information in this short space.

7 I had a question on page 15, and it relates to  
8 what you showed us on slide 5. And it was a sentence about  
9 furnishing more office visits using billing code 99214, and  
10 I'm kind of curious because also in the chapter, you talk  
11 about beneficiaries getting younger, so presumably a bit  
12 healthier. Do you have any sense of what is leading to  
13 that more intense billing code use?

14 MS. BURTON: I haven't done an analysis. I have  
15 two theories that are completely untested. One is that  
16 there could be favorable selection of healthy beneficiaries  
17 going into MA, leaving sicker beneficiaries in fee-for-  
18 service, and it's also possible that there's just like a  
19 secular trend towards preferring the 99214 code over the  
20 99213 code by clinicians.

21 DR. CHERNEW: Let me give what might may or may  
22 not be a clarifying answer/question. Some of that could be

1 a change in the actual care that's delivered, right? Some  
2 of it could be a change in the way in which the care that  
3 is delivered is coded, and I think, Rachel, you would  
4 include both of those in your definition.

5 MS. BURTON: Yep.

6 DR. DAMBERG: Yeah. Because I guess what I was  
7 trying to unpack a little bit is, you know, the words that  
8 I hear on the street from primary care physicians is  
9 they're being asked to do a lot in those primary care  
10 visits and how much of that is sort of baked into using  
11 that higher-level code.

12 MS. KELLEY: Betty?

13 DR. RAMBUR: So I had that same comment that  
14 Cheryl said so much better than I did in terms of can we  
15 get more granularity about what's under the intensity  
16 changes.

17 And then the other question I had -- and this is  
18 just because I'm curious -- on page 8, it talked about we  
19 can get private in-network only, no out-of-network, and I'm  
20 not wanting to go to rabbit hole about that. But I was  
21 curious, given all the emphasis on surprise billing and  
22 everything, why we weren't able to access that information.

1 MS. BURTON: It's just a limitation of the data  
2 source that we use for that graph. We would happily  
3 include that if we had it.

4 MS. KELLEY: Brian?

5 DR. MILLER: I love this chapter, and I also have  
6 to say I love the new slide deck format. It's much easier  
7 to read.

8 I just had a couple clarifying questions. One,  
9 on page 11, I really loved that discussion on  
10 consolidation. I thought that that was excellent. I think  
11 one thing we may want to do is clarify and be more distinct  
12 when we're looking at consolidation within the delivery  
13 system for vertical consolidation, hospitals buying clinics  
14 versus payer-provider consolidation -- I'm sorry - into  
15 vertical integration. And so we may want to clarify that.

16 Another question I had on that page was about the  
17 4 percent of physicians reporting private-equity ownership  
18 in their practice and how this may drive consolidation. Do  
19 we have any evidence that suggests that a 4 percent market  
20 share, market participant is driving consolidation?

21 MS. BURTON: I'm going to ask Jeff Stensland to  
22 join me up here because he's the one that has the updated -



1 -

2 DR. CHERNEW: This might be a Round 2.

3 So the question would be, what do we -- there's a  
4 Round 2 question about aspects of that, but if Jeff wants  
5 to add now, go ahead.

6 DR. STENSLAND: We haven't done any analysis of  
7 what would be triggered by that 4 percent figure.

8 DR. MILLER: So it sounds like we should consider  
9 modifying or deleting that sentence.

10 Thank you.

11 MS. KELLEY: Amol?

12 DR. NAVATHE: Thanks, Rachel. As always, very  
13 good chapter and a lot of information in there.

14 I have a couple of quick -- quickish questions.  
15 So on page 23, 24, there's this note about the suggestions  
16 for the MA quality program being scored by the CBO and  
17 generating \$10 billion of savings out of the \$65 billion  
18 for Part A, but then there's this note around that \$10  
19 billion would be Part A and Part B. And so that kind of  
20 just prompted me, and I apologize if this is somewhere  
21 else. But not only out of that \$10 billion, how would that  
22 spread between Part A and Part B, but more broadly for MA,

1 what is the mix of Part A and Part B?

2 MS. BURTON: That's a great question. I can  
3 consult with my MA colleagues and try and add that to the  
4 paper.

5 DR. NAVATHE: Okay, great.

6 A second question point --

7 MR. MASI: On that point --

8 DR. NAVATHE: Sorry.

9 MR. MASI: -- we'll follow up with a more precise  
10 number, but I think, in my mind, I carry that the Part B  
11 share is roughly 55 percent and kind of increasing at a  
12 clip.

13 DR. NAVATHE: Okay. Thanks. That's helpful to  
14 have that.

15 The second question I had is, on page 33 in the  
16 access to care section, there's a number of different  
17 contrasts between Black beneficiaries, Hispanic  
18 beneficiaries, and White beneficiaries in terms of access  
19 to care and also in terms of ability to pay. For example,  
20 I think there was -- or issues with paying 16 percent of  
21 Black beneficiaries report issues with paying a medical  
22 bill versus 6 percent for White versus 10 percent for

1 Hispanic. And I was curious, is that -- that seems like  
2 it's overall. Do we have a sense of how that works when we  
3 stratify by dual-eligibility status, for example?

4 MS. BURTON: Oh, like combining race and  
5 insurance type?

6 DR. NAVATHE: Yeah, exactly. So when you look  
7 within dual eligibles --

8 MS. BURTON: Mm-hmm.

9 DR. NAVATHE: -- and then compare -- and outside  
10 of the dual eligibles or partial and full duals, how do  
11 those contract? How do they --

12 MS. BURTON: Yeah. I haven't done that analysis  
13 yet. I don't know if we have the cell size to allow us to  
14 go that deep, but I can explore that for sure.

15 DR. NAVATHE: Okay. Thank you.

16 MS. KELLEY: Jaewon?

17 DR. RYU: Yeah. My question had to do with the  
18 estimate on the Part A trust fund, the 2031 versus 2033,  
19 between the trustees versus the CBO. Do we know what the  
20 major assumption differences are that drive that two-year  
21 difference?

22 MS. BURTON: I don't, but Paul might actually.

1 [Laughter.]

2 MR. MASI: I gave up honest work after I left  
3 CBO.

4 That's a great question. I think both are -- I  
5 think there are differences in both projections of spending  
6 and on the revenue side, but we can follow up with a more  
7 precise breakdown.

8 MS. UPCHURCH: Thank you. Great chapter.

9 One question I have -- and this is not just a  
10 MedPAC issue but a consumer sort of advocate issue around  
11 health insurance literacy and how we talk about it -- the  
12 word "supplement," "supplemental" is used so many times for  
13 so many different reasons. If you think about Part B as  
14 supplementary Medicare medical insurance, you think about  
15 supplements that go with original Medicare. Now we call  
16 the additional things with Medicare Advantage often  
17 "supplemental benefits." It's really confusing to  
18 consumers. So I'm wondering if we could adopt the language  
19 -- I was looking at the plan finder. They do call them  
20 "extra benefits" with Medicare Advantage plans. Just to  
21 clarify the language a little bit there.

22 You also have -- we sometimes talk about coverage

1 with traditional Medicare, and we call it "supplemental  
2 coverage," but we're talking about the employer coverage or  
3 Medicaid. If we could call that "secondary coverage," and  
4 that could be a supplement or Medigap policy, employer  
5 coverage, and/or -- so just language so that we can  
6 potentially make it a little clearer to folks.

7           And then -- and I'm not sure if this is Round 1  
8 or Round 2 question, but you mentioned COVID testing and  
9 how we had waiving some of the payments, Medicare payments.  
10 I know there's been a lot of fraud with that. It happened  
11 to me helping a family member, and when I called to talk  
12 about it, I heard that was a really common problem. So I'm  
13 wondering if we might want to pursue that because consumers  
14 could just directly order without having to go through a  
15 provider, and I think that's one of the very few times  
16 Medicare has allowed that, if we want to peek at that.

17           And then, lastly, we talked about Part D cost  
18 sharing going down, and I believe that with the Inflation  
19 Reduction Act, but I'm just wondering if we have any data  
20 to clarify how the patient assistance programs from the  
21 drug manufacturers may react to this and what that means in  
22 terms of -- like we help a lot of people with patient

1 assistance programs. Well, are they going to be eligible  
2 for those moving forward? Do we have any data related to  
3 that?

4 Thanks.

5 MS. BURTON: I've made a note of all those  
6 things, so thank you.

7 MS. KELLEY: I think that's the end of Round 1,  
8 Mike.

9 Okay. For Round 2, we have Stacie.

10 DR. DUSETZINA: Thanks for this awesome work,  
11 Rachel. I really love this chapter every year. I find it  
12 always to be pretty disturbing in a way of just how much  
13 we're dealing with for spending increases over the next 10  
14 years or so.

15 I had a couple of comments, one being that when  
16 we talk about some of the big moves that we could do to try  
17 to change the trajectory, we mentioned hospital cuts and  
18 payroll tax increases, and for some reason, I kind of was  
19 thinking it would be nice to know like if we could say  
20 anything about what the implication of a payroll tax  
21 increase would be. It's like I think we talk a lot about  
22 thinking about the payments to physicians and hospitals,

1 and the implications there seem clearer to me. But I  
2 wasn't -- I mean, I'm sure it's probably an obvious thing,  
3 like the payroll taxes increase, and then that's a problem  
4 because wages can't go up or something.

5 DR. CHERNEW: So I will say, I don't want to  
6 speak for economists. This is not my area of economics,  
7 but it is not an obvious thing.

8 DR. DUSERZINA: Okay. Good, good.

9 DR. CHERNEW: Obviously, the labor supply impacts  
10 of payroll taxes matter. The investment impacts of labor  
11 supply matters. There's issues about what it means if you  
12 deficit finance things. So there's a lot of competing  
13 issues about the economics around taxes writ large. My  
14 personal opinion is it also depends on where you are in the  
15 scheme of taxes, right? So if you're raising a little bit  
16 from a small level -- so there's a lot of issues, I think,  
17 around the tax side.

18 As a general rule -- and I cede to Paul -- we  
19 avoid more of the financing issues and how do we get into  
20 the consequences of the financing, because I think it's a  
21 little bit outside of our general remit. That does not  
22 make -- get unimportant. In fact, I think it's quite

1 important, but that's my take on where we are on that.

2 Paul?

3 DR. DUSETZINA: Yeah. Maybe it's not like an  
4 extensive elaboration of how this works, but it feels like  
5 one of those things we're like okay, then why don't you  
6 just raise the payroll tax? And I know that that would --  
7 it would be illogical and probably would break a lot of  
8 things, but it feels like we're trying to say something  
9 about how severe of a situation we're in. And maybe it  
10 just --

11 MR. MASI: Yeah. Thanks for raising that,  
12 Stacie. We'll take that back and see if there's a way we  
13 can clarify.

14 I would emphasize what Mike said. Our mission is  
15 really to focus on Medicare payment issues, and so we'll  
16 want to be careful that we're staying comfortably in our  
17 lane, but we'll see if there's a way to clarify.

18 DR. CHERNEW: I just will add. Raising taxes, in  
19 general, is a bad just -- right?

20 DR. DUSETZINA: Yeah.

21 DR. CHERNEW: The problem is borrowing more also  
22 has deleterious consequences.



1 DR. DUSETZINA: Yeah.

2 DR. CHERNEW: So the tension and just for the  
3 public at home, our broad remit is to make recommendations  
4 about payment levels that will enable beneficiaries to have  
5 access to high-quality care. The way in which that is  
6 financed, particularly even the demographic challenges and  
7 the technologies we want people to access -- the way in  
8 which that is financed is an unbelievably important,  
9 contentious, and complex issue.

10 But I'm glad Paul has agreed to think about what  
11 we can say.

12 DR. DUSETZINA: Thank you.

13 Okay, more in my -- our lane, on page 27, when  
14 you're talking about the out-of-pocket spending on premiums  
15 and services, I did wonder if it would be possible to  
16 separately state what it looks like for fee-for-service  
17 standalone plans and MA plans kind of separately. I think  
18 that would be a useful addition there.

19 I also wondered if it would be possible to add  
20 information on what the average premiums are for -- to  
21 Gina's language, "secondary coverage." So for the -- what  
22 we've labeled as supplemental coverage for the fee-for-

1 service plans, if that information is available.

2           And then just one minor note around language, in  
3 the chapter on page 31, it refers to people being less  
4 costly, and I think we changed that language, instead of  
5 being about the person being -- maybe requiring lower-  
6 intensity service use or something, just a slight  
7 reframing.

8           MS. BURTON: I will again look into some of  
9 those data sources, but some of them, I've tried to find in  
10 the past and haven't been able to find them. But I'll take  
11 another pass.

12           DR. CHERNEW: Amol added on this point.

13           DR. NAVATHE: Yeah. I had it on this point, on  
14 the payroll tax point. I think I -- this may have preceded  
15 you, but I think I may have been the reason that that got  
16 added. And I think that the spirit of it was basically to  
17 try to put into a more relatable sense, like what the  
18 impact or change would need to be. And so I think it was  
19 less around like this is what the policy would need to  
20 change and more just context for like why does this matter,  
21 why is this important to the median family in the U.S. And  
22 so maybe it just requires a little bit more context for why

1 we're putting it in there as opposed to inadvertently  
2 suggesting that some sort of policy option or something  
3 like that.

4 MS. KELLEY: Betty.

5 DR. RAMBUR: Thank you. I'll just chime in on  
6 that. I think that an illustration of those tradeoffs is  
7 really important with the policy directives. This is  
8 really needing to be detailed.

9 So thank you for this chapter. I just have to  
10 say I appreciate the tone, because as I'm reading it, I  
11 start feeling like my hair is on fire, and it feels like a  
12 lot has to be done immediately.

13 One thing that I really encourage us to add is  
14 some of the other areas that Medicare is financing or  
15 supporting. I'm thinking, not surprisingly, graduate  
16 medical education, and we don't have to take a stance on  
17 that. But I think it's fair that the \$18 billion a year we  
18 spend on that is at least referenced in here. And I know  
19 some would say this is absolutely essential for educating  
20 physicians, and others would say it's an asset to teaching  
21 hospitals. But I think at least, you know, without  
22 judgment either way, and there might be others, other areas

1 that we are spending. And so that would be the main thing  
2 that I would encourage us to add.

3 Thank you.

4 MS. KELLEY: Brian.

5 DR. MILLER: Thank you.

6 So a couple things that I think we should  
7 correct, but before that, I do agree with Betty. I think  
8 that we should mention GME, and we should also probably  
9 note that there is zero dollars spent on graduate nursing  
10 education.

11 On page 2, we note that one of the most effective  
12 ways that the Medicare program can control spending growth  
13 is by setting prices, yet on page 1 and page 15, we note  
14 that volume and intensity of care in a fee-for-service  
15 setting modulate the cost, and that if we engage in price  
16 regulation, that doesn't work. I think we should eliminate  
17 that sentence, especially since evidence tends to suggest  
18 that capitation and population-based payment is the most  
19 effective way to control Medicare spending.

20 Another thought I noticed, on page 12, we  
21 mentioned that we discussed the difference between Medicare  
22 and commercial payment rates, and we said that access may

1 depend upon restraining commercial payer rates. I think  
2 that's outside of our scope, and we should probably  
3 eliminate that discussion.

4 I do also think that that distinguished from  
5 health systems about payer and which patients they see  
6 first is already happening, and we should mention that that  
7 is already happening, not to name any names.

8 Another couple of comments I noted on MA, on page  
9 17, we said that MA costs more -- substantially more per  
10 beneficiary than traditional fee-for-service Medicare. I  
11 think this is a little misleading. It should be modified  
12 because they have different benefits packages, and we could  
13 say maybe on statutory program spending, MA costs more.  
14 But on an apples-to-apples basis, when you look at the MA  
15 benefits package, which is A plus B, Med Sup, a PDP and  
16 supplemental benefits, that's not exactly a fair or  
17 accurate comparison.

18 And then on page 21, we noted that MA plans  
19 receive quality bonuses without providing meaningful  
20 information about the plan's quality of care. I don't  
21 think that that is an accurate statement because we have  
22 the star ratings, which, you know, many of us think are

1 definitely due for improvement. But I looked up the  
2 technical guide, and it's 203 pages long with a variety of  
3 measures. So we might not think that those measures are  
4 great, or we might not think that the star ratings is the  
5 way to do things. But it's not accurate for us to say that  
6 doesn't provide meaningful information about the plan's  
7 quality of care.

8           And then on page 20, I would say that there was a  
9 comment about favorable selection into the MA program, and  
10 I know that we have a lot of analysis on this. But I  
11 wonder about this because it's hard on face value with the  
12 commonsense test that you have favorable selection into a  
13 program that has 51 percent market share. Individual plans  
14 may be engaging in favorable selection, but I wonder if  
15 half the Medicare program can engage with favorable  
16 selection. That doesn't exactly make sense to me.

17           DR. CHERNEW: So can I just respond to that part?

18           DR. MILLER: Yeah.

19           DR. CHERNEW: If you had a Medicare program which  
20 had a bell-shaped health status distribution, which it  
21 doesn't because it's very skewed, but just for this  
22 purpose, if the people to the healthy side of the bell

1 curve all joined one part of the program and people -- even  
2 if 75 other people on one side all joined one part of the  
3 program and the other 25 didn't, you would have favorable  
4 selection. The amount of favorable selection you have  
5 isn't mathematically connected. You could have a very  
6 large chunk of the program in one sector, still have  
7 selection being favorable towards that sector.

8 DR. MILLER: And to respond to that, I think that  
9 gets to our later discussion today about coding intensity,  
10 which I have lots of questions about, which I'll save for  
11 that session.

12 DR. CHERNEW: Yeah. And just as an aside, we  
13 will have a separate section on selection, and the  
14 distinction between coding and selection is actually an  
15 important one, but we will save that. I agree.

16 DR. MILLER: Right. But I feel particularly  
17 strongly about the MA versus fee-for-service comparison.  
18 It needs to accurately reflect the different benefits  
19 packages, especially since from a statutory program  
20 spending perspective, we are responsible for PDP and for  
21 the beneficiaries. I mean, not who are enrolled in  
22 Medicaid. The Medicare Programs Office, they're not

1 responsible for that, but that is still a statutory program  
2 spending for the taxpayer. So I think that that discussion  
3 needs to be updated and more reflective that the programs  
4 are quite different.

5 Thank you.

6 MS. KELLEY: Larry is next in the queue, and so I  
7 will read his comment: The chapter does a good job briefly  
8 summarizing the evidence about different forms of  
9 consolidation and their impact.

10 He also appreciates that this discussion is  
11 placed first in the chapter.

12 He thinks it would be useful if the chapter  
13 explicitly mentioned that although consolidation does not  
14 affect the prices Medicare pays, at least in the short run,  
15 it may affect quality for Medicare patients. This is  
16 implied in the chapter but not stated.

17 He suspects that consolidation reduces  
18 competition and that less competition means lower quality  
19 sooner or later.

20 He thinks that it might be good in the MA section  
21 to briefly mention the extent of consolidation in the MA  
22 insurer market and to mention that the overpayments to



1 these consolidated insurers help them vertically integrate  
2 by acquiring physician practices.

3           And finally, in the financing challenge part of  
4 the chapter, various data are presented regarding the  
5 extent of the challenge and the extent to which spending  
6 would have to be reduced, and the chapter states that  
7 replacing the MA quality incentive plan with MedPAC's  
8 proposed VIP would save \$10 billion annually compared to a  
9 \$65 billion annual Part A deficit. And then in  
10 parentheses, he says, "I think I have this right."

11           Might it be useful to add in estimates for how  
12 much could be saved by dealing with diagnostic coding  
13 intensity and with benchmarks that are too high?

14           And next, I have Amol.

15           DR. NAVATHE: Thanks, Rachel. So always a  
16 startling set of facts. Obviously, some of the timelines  
17 and stuff have shifted over time, even since I've been on  
18 the Commission. I was particularly struck by the figure  
19 that showed by 2042, basically any spending beyond Medicare  
20 spending would be adding to the deficit, which is obviously  
21 potentially very, very problematic.

22           In any case, the comment that I wanted to make

1 here is a bit of a comment, a bit of a question, but I  
2 think on page 27 of the paper -- and there's nothing  
3 explicit that I'm going to ask you to respond to here --  
4 you outline sort of the cost sharing implications for a  
5 beneficiary. So what is the cost sharing basically? That  
6 is paired prior to that, I think, with some discussion of  
7 supplemental coverage and the share of that. What I  
8 was thinking -- and I know this chapter is always packed  
9 with information and constrained for space. So I will not  
10 be hurt if it doesn't make it into the final version, but I  
11 think it's just worth mentioning is it would be helpful to  
12 understand a little bit about the trends here over time,  
13 particularly on the cost-sharing piece of it, because I  
14 think one of the points that is made earlier in the chapter  
15 is that as prices and intensity go up, that the cost-  
16 sharing burden for beneficiaries also goes up.

17           And I think one of the challenges with a chapter  
18 like this is it's so dense with a bunch of information. I  
19 think the question is, how do we make that information tell  
20 the story that we're trying to tell rather than just be a  
21 deluge of facts? And that's why I think, to some extent,  
22 if we really care about -- we care about the government

1 spending, obviously, but I think from the beneficiary  
2 perspective, they care about what it means for them. And  
3 so I think if we could have some adapting of a figure or  
4 table or something to reflect how those trends are expected  
5 to grow, I think that would be potentially very helpful.  
6 But again, subject to space limitations, I will not be  
7 offended if we don't, if we can't squeeze it in.

8 MS. KELLEY: Tamara.

9 DR. KONETZKA: A couple of comments. First of  
10 all, thank you, Rachel. This was a great chapter. I  
11 especially appreciated the very sort of clear explanation  
12 of the demographics and what to expect.

13 My question is not about that, though. It's  
14 about -- or my comment is about the intensity of services.  
15 You gave the example of the one coding example, but I think  
16 when I really think about context of these trends, I would  
17 love to see a slightly more granular breakdown of spending  
18 trends in intensity and service mix beyond just sort of  
19 Part A and Part B. And so when we think about all the  
20 policies that Medicare has implemented to try to contain  
21 costs or indirectly or directly over the years, a lot of  
22 things like bundled payments or the shift from inpatient to

1 outpatient settings for some kinds of procedures, I think  
2 to kind of inform that and inform the context of those  
3 policies, it would be great to see what's been the trend in  
4 service mix and intensity of post-acute care use and  
5 hospital use sort of separately beyond just Part A and Part  
6 B.

7           And yeah, I mean, I guess one could get very  
8 granular, but I just think those big buckets like hospital  
9 care, post-acute care, specialty care, primary care,  
10 something like that might be very helpful for context. So  
11 that was my main comment.

12           The other one, I just wanted to react to  
13 something about the consolidation, which is, of course,  
14 that it may not affect prices directly when providers  
15 consolidate if Medicare sets those prices, but we've seen  
16 lots of evidence in the research that they still can affect  
17 spending, right, and that you might have -- like in post-  
18 acute care, for example, when we saw under vertical  
19 integration between hospitals and post-acute care  
20 providers, we just see a different mix of services that  
21 patients start to use after consolidation, which sort of  
22 increases profits and increases Medicare spending. So it

1 indirectly at least affects spending, if not priced  
2 directly.

3 Thank you.

4 MS. KELLEY: Robert?

5 DR. CHERRY: Thank you. First and foremost, I do  
6 like the new slide format. So it's really clean and crisp.  
7 So I wanted to mention it, and thank you for that effort.

8 The chapters, I just want to echo the sentiments  
9 of the other Commissioners that it's very well done and  
10 very cleanly written.

11 I have a few comments. They're modest comments  
12 for feedback. Both in the summary but as well as on page  
13 14, it's mentioned about the slower-than-usual growth  
14 during the pandemic, and I do agree that in terms of non-  
15 COVID care, there were decreases in morbidity, and there  
16 was a shift towards more outpatient procedures and  
17 surgeries, and that helped to offset some of the costs.

18 I think a missing component was that there was  
19 also this massive cancellation of elective surgeries and  
20 even some elective medical admissions as well that also  
21 drastically reduced the cost. So I think mentioning that  
22 would kind of complete the narrative.

1           There was also some fear of actually going into  
2 emergency departments and into doctor's offices as well,  
3 particularly those that had already preexisting conditions.  
4 So I think kind of rounding out the reasons could be  
5 helpful.

6           The other thing, regarding intensity of services,  
7 in the example that was given was that providers may be  
8 ordering CT scans instead of x-rays, it may be  
9 oversimplifying the issue just a little bit, particularly  
10 for clinicians that may be reading this chapter.

11           I think a couple of better examples, for example,  
12 is that CT scans over the years have improved their  
13 resolution. So there's a lot of high-resolution CT scans  
14 out there, and so what is also happening is that there's  
15 that now early pathology, unrelated to the reason why the  
16 CT was ordered in the first place, that is now being  
17 captured, leading to additional workup, diagnosis, and  
18 treatment as well. And these high-resolution CTs are also  
19 picking up incidental findings that are benign but  
20 nevertheless may prompt additional workup and expense and  
21 costs as well.

22           An alternative example could be the increased use

1 of MRI-guided biopsies, prostate biopsies, and that's being  
2 utilized to reduce the number of blind biopsies or even  
3 missed lesions by using ultrasound alone. So it's more  
4 expensive but diagnostically better for the patient. So I  
5 think those examples may be better than we're using CT  
6 scans instead of x-rays.

7           And then the final comment is regarding low  
8 versus high decision-making. I'll review -- I'll reserve  
9 some of my more substantive comments around coding  
10 intensity for later today, but I do agree that there should  
11 be some slight reframing of what you're trying to get at so  
12 that there aren't unintended consequences of the statement,  
13 because there are patients that may come into a physician's  
14 office who have a very specific problem. They're coming in  
15 for an upper respiratory illness or flu-like symptoms, and  
16 it is theoretically low decision-making, but what's  
17 happening is that the provider is also in tune to all these  
18 other alternative payment models, both public and  
19 commercial. So they're also paying attention to their  
20 health maintenance needs. So even though they're there for  
21 a very specific problem, they may also be talking about  
22 delays to cancer screening or remember to get your

1 vaccination that's coming up or, by the way, "I see your  
2 blood pressure is a little bit elevated," and they have a  
3 conversation around that. And all of a sudden, the focus  
4 problem area and the low-intensity decision-making gets  
5 kicked up to a moderate level because there's a lot of  
6 population health drivers out there around all patients,  
7 regardless of the payer that is behind the patient. So  
8 some retooling of that so that it makes sense to others  
9 would be helpful.

10           Otherwise, I think it's a great chapter, well  
11 done, and just a few modest comments for your  
12 consideration.

13           Thank you.

14           MS. KELLEY: Cheryl?

15           DR. DAMBERG: Thank you.

16           Again, many thanks for this chapter. As Betty  
17 said, it's very - it puts your hair on fire. I think Amol  
18 said "sobering," and I would say this is sort of required  
19 reading for every American in this country to have a sense  
20 of what's happening in this space.

21           I just want to emphasize the importance of the  
22 section on consolidation. So I'm going to plus-one



1 tomorrow, Larry and Brian, and I do think the consolidation  
2 piece should add in -- and this also pertains to another  
3 one of the chapters we reviewed around ASCs related to  
4 payer-provider consolidation and making sure that's  
5 spotlighted, because that seems to be an increasing trend  
6 in the marketplace.

7           The other thing that I wondered -- so we talk  
8 about raising payroll taxes and reducing spending, but I  
9 think it would be helpful to maybe spotlight in brief, the  
10 ways in which we think about reducing spending. So much of  
11 the focus has been on redesigning the health care system  
12 through different payment models to gain efficiencies. But  
13 also, I think in the space of price setting, clearly with  
14 the Inflation Reduction Act, the ability to negotiate on  
15 prices and to do that more effectively and especially in  
16 light of some very expensive technologies and drugs that  
17 are about to come online, I think it would be helpful to  
18 spotlight that.

19           MS. KELLEY: Brian, you had something you wanted  
20 to add.

21           DR. MILLER: Yeah. I wanted to actually build  
22 off two folks' comments. One is Larry's comment about star

1 ratings is an important one, and I think we should also  
2 note that the quality regulation and oversight systems  
3 between MA and fee-for-service are very different, and as a  
4 result, that creates an unequal playing field. And we  
5 should think about how we can equalize the playing field  
6 between MA and also the fee-for-service plan option that  
7 beneficiaries have.

8 I actually disagree with Robert on the intensity  
9 example. I really enjoyed that and wanted to say I was  
10 very happy to see that in there, and I would actually  
11 suggest that we add another one about time-based billing.  
12 The joke goes that the intensivist is bulling 90 minutes of  
13 critical care time for 30 patients in a 10-hour shift. So  
14 I see that that is commonly abused in clinical practice.  
15 That may be because payment rate levels are low, and we can  
16 also note that. But we should note the concern about  
17 increased abuse of time-based billing.

18 MS. BURTON: It's tricky when we don't have a  
19 source for that. So if you have something, please send it  
20 to me.

21 DR. MILLER: I'll check.

22 MS. KELLEY: I have a comment from Greg. Greg

1 says this is a very nice summary of extremely complex  
2 issues. He was going to make several of the same points  
3 that Robert made regarding increased complexity and  
4 changing diagnostic and treatment modalities. Robert said  
5 it very well, in Greg's opinion, so he would like to simply  
6 second what Robert said.

7 DR. CHERNEW: Perfect. And if I follow, that is  
8 the end of our Round 2 queue since we aren't -- because  
9 this is largely context, I think what I'm going to do is  
10 just summarize where I think we are and what we heard.

11 So first, let me say thank you all for the  
12 comments. They've all been noted, and we will make changes  
13 where we can. I'm apologetic in advance if you don't get  
14 your change in, but they will all be considered, as is  
15 always the case.

16 I will say two things that I would just highlight  
17 in this conversation as being important -- and again, I'm  
18 not sure where we'll go -- the first one is I do think  
19 workforce could be highlighted more in a number of ways. I  
20 think we face a lot of workforce challenges that come up in  
21 our physician chapter. And I think we could highlight some  
22 of the top-line points there around workforce writ large,

1 both physician and nonphysician, primary care specialists.  
2 I think that's -- I think the workforce is, at the end of  
3 the day, what's creating value in the health care sector.  
4 I think that's a valuable thing to say. So, Betty, thank  
5 you for that.

6           And I've heard several people say -- and some of  
7 you know we have had a lot of back-and-forth over the past  
8 emails on consolidation, and I think the point Brian -- I  
9 think you raised first is spot on, which is the different  
10 types of consolidation have different effects.  
11 Consolidation of providers and insurers is different than  
12 consolidation between providers. Vertical and horizontal  
13 consolidation is different. I think tomorrow -- you're  
14 spot on. I think we actually don't spend a lot of time  
15 thinking about consolidation in the post-acute space, and I  
16 think there's some very unique aspects of what happens to  
17 consolidation there.

18           I would emphasize that the chapter by its nature  
19 does a reasonable job when it's describing things that are  
20 happening.

21           Look at all this consolidation. It is not  
22 necessarily the best venue for tying into -- therefore, it

1 creates all of these various issues which, of course,  
2 people would like it to say, I would like it to say in many  
3 ways, but a lot of times that these are the consequences of  
4 this is much less of a fact-based statement. We can  
5 observe consolidation. Knowing the impact of that  
6 consolidation remains somewhat of a -- more of an  
7 evaluative exercise, and the issues are quite complex.

8           But nevertheless, I think where we are now is we  
9 will take those and the other comments that were made under  
10 consideration. Rachel has a lot on her plate. She's doing  
11 a lot of the work, for example, on the physician fee  
12 schedule stuff. So we will make edits where we can as we  
13 review everything, but other than that, I think I just want  
14 to say thank you to Rachel for doing this. Everybody  
15 really does -- I'm not prepared to say that every American  
16 should read it, although I'd be happy if they did. But  
17 that's not an official MedPAC recommendation. But in any  
18 case, I really do appreciate the work and appreciate the  
19 comments.

20           And we're now in a moment going to break for  
21 lunch. I will say for those of you at home and want to get  
22 your comments in on this context chapter, please reach out

1 to us, and you can find us on our website. You can find us  
2 at -- I think it's MedPAC meetings -- I'm sorry. I don't  
3 have the -- I take it back. I do. It is  
4 MeetingComments@MedPAC.gov. So you can send us messages  
5 there to the website and let us know your thinking about  
6 these things, and we are going to come back to talk about  
7 several Medicare Advantage issues after lunch.

8 So, Paul, do you want to add anything?

9 MR. MASI: No.

10 DR. CHERNEW: Then we are adjourned, and we will  
11 see you all back here. I think we are coming back at 1:15.

12 Yep. All right. Thank you, everybody.

13 [Whereupon, at 11:43 p.m., the meeting was  
14 recessed, to reconvene at 1:15 p.m. this same day.]

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## AFTERNOON SESSION

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[1:16 p.m.]

4

DR. CHERNEW: Hi, everybody. Welcome back to our afternoon session. We're going to spend this afternoon talking broadly about Medicare Advantage. Medicare Advantage program is now half -- a little more than half, depending on how you count -- a rising share of the Medicare program. So while in the past, we might have thought we had the traditional Medicare program with sort of a side Medicare Advantage program. Now we have a Medicare program, which really is substantively comprised of Medicare Advantage plans, and as we have noted over the years, there's a number of challenges with the policies related to those Medicare Advantage plans.

16

We have -- I think it's five -- Dana will correct me if I got this wrong -- chapters on Medicare Advantage plan going forward. We're going to discuss them in a minute, and I know from talking to some of you, there's things that might not be clear how it fits into those different types of chapters or other Medicare Advantage issues.

22

1           So we thought it would be useful for both the  
2 Commissioners and, honestly, the public to understand sort  
3 of the broad outlines of what we're planning in terms of  
4 Medicare Advantage work.

5           All of these topics will be discussed  
6 individually, some of them today, as we move forward, but  
7 this somewhat shorter session is designed to just provide a  
8 broad overview.

9           And what I'm going to recommend we do, because  
10 the session is somewhat shorter, is we just forego Round 1  
11 and we just have Round 2 questions, and you just try and  
12 say what you're going to say. And again, please be  
13 somewhat brief, because it's a shorter session, but I think  
14 we'll just try it in one round and see where that goes.

15           And so if I got that all right, we're going to  
16 Stuart.

17           MR. HAMMOND: Good afternoon. This presentation  
18 provides an overview of work relating to the Medicare  
19 Advantage program that the Commission has planned for the  
20 upcoming cycle.

21           The audience can download a PDF version of these  
22 slides in the handout section of the control panel on the



1 right side of the screen.

2 We will begin today's presentation by reviewing  
3 the importance of MA payment policy for the Medicare  
4 program. We will then provide an overview of the MA-  
5 related topics that the Commission plans to cover in the  
6 upcoming analytic cycle.

7 This year, we are planning five chapters relating  
8 to Medicare Advantage. We plan for two chapters to be  
9 included in the March 2024 report and for three to be  
10 included in the June 2024 report. For today's  
11 presentation, we will provide a brief overview of each of  
12 the five topics. We will review the Commission's prior  
13 work on the topic, and we will discuss the direction of our  
14 planned analysis.

15 Medicare Advantage is an important part of the  
16 Medicare program. MA gives Medicare beneficiaries the  
17 option to receive benefits from private plans rather than  
18 from the traditional fee-for-service Medicare program.

19 In MA, Medicare pays private plans on a capitated  
20 basis, meaning that the plan receives a fixed monthly  
21 payment to cover the medical expenses of Medicare  
22 beneficiaries enrolled in the plan. In 2023, a majority of

1 Medicare beneficiaries are now enrolled in MA.

2 Reflecting the large and growing significance of  
3 MA, the Commission is planning to produce five chapters  
4 about MA this cycle. The March report will include two MA  
5 chapters.

6 First, as we do every year, we will produce a  
7 status report that provides updated statistics about the MA  
8 program and updated analyses of key policy issues in MA.  
9 We will also complete a congressionally mandated report  
10 about special needs plans, the second in a series of  
11 mandated reports on this topic. We also plan to include  
12 three chapters relating to MA in the June 2024 report.

13 In the first, we plan to continue our work  
14 exploring the question of whether to standardize MA benefit  
15 packages. You will hear the first presentation on this  
16 topic from Eric later this afternoon.

17 We plan to also present an updated framework for  
18 evaluating access and quality in MA and to update our  
19 assessment of MA encounter data.

20 As discussed in the previous slide, we are  
21 planning two MA-related chapters for the March 2024 report.  
22 Each year, the Commission includes in the March MA Status

1 Report, the latest data on plan enrollment and  
2 availability, bids, payments, risk adjustment, and quality  
3 in Medicare Advantage. We plan to continue providing this  
4 information this year.

5 In recent years, our March report has also  
6 included an analysis of coding intensity and the extent to  
7 which more complete coding of diagnoses in MA relative to  
8 fee-for-service increases payments to plans.

9 As a reminder, the Commission has had a standing  
10 recommendation since 2016 to fully account for MA coding  
11 intensity.

12 Last year, we also presented an assessment of  
13 favorable selection into MA. We found that in the year  
14 prior to joining MA, beneficiaries who went on to enroll in  
15 MA were less expensive to insure than beneficiaries with  
16 the same risk score who remained in fee-for-service.  
17 Because MA benchmarks are based on the cost of fee-for-  
18 service beneficiaries, favorable selection results in  
19 overpayments to MA plans. Those results were included in  
20 our June 2023 report.

21 Beginning this year, we plan to annually provide  
22 our latest estimate of favorable selection as part of the

1 March status report.

2           The second of our two March MA chapters will be a  
3 congressionally mandated report on D-SNPs. D-SNPs are a  
4 type of special needs plan that serve beneficiaries who are  
5 dually eligible for both Medicare and Medicaid.

6           The Bipartisan Budget Act of 2018 permanently  
7 authorized D-SNPs and mandated that the Commission  
8 periodically compare the performance of D-SNPs and other  
9 plans that serve dual-eligible beneficiaries.

10           This fall, we will present our second report on  
11 this topic, and the results will be included in our March  
12 2024 report to the Congress. We will use HEDIS and CAHPS  
13 quality measures to evaluate the performance of D-SNPs and  
14 other plans. We will present an update on trends in the D-  
15 SNP market and discuss CMS's plan to end a demonstration  
16 program that was testing different approaches to  
17 coordinating care and financing across Medicare and  
18 Medicaid.

19           Now I'll turn it over to Katelyn who will discuss  
20 the work plan for the June report.

21           DR. SMALLEY: Thank you, Stuart.

22           Our first planned June chapter will continue a

1 line of work exploring the merits of standardizing certain  
2 aspects of the MA benefit package. The MA coverage options  
3 that are available to beneficiaries are highly variable,  
4 both across and within local markets, which may make it  
5 difficult for beneficiaries to identify a plan that best  
6 fits their coverage needs.

7           As the Commission began to discuss last year,  
8 standardizing certain types of MA benefits could make it  
9 easier for potential enrollees to compare plans and assess  
10 the extent to which they would meet their needs.

11           Eric will describe some options for standardizing  
12 benefits in the next presentation.

13           Next, we will be revisiting our approach to  
14 quality and access to care in Medicare Advantage. CMS  
15 currently uses a five-star rating system to assess quality  
16 in MA, using data sources including HEDIS, CAHPS, and  
17 administrative data to evaluate clinical outcomes and  
18 patient experience at the MA contract level.

19           Star ratings are also the basis for the Quality  
20 Bonus Program. The QBP is intended to allow beneficiaries  
21 to compare across coverage options as well as to reward MA  
22 organizations for the quality of care provided to their

1 enrollees. We've estimated that the QBP has resulted in  
2 \$16 billion in additional MA payments in 2023.

3           However, the Commission has also determined that  
4 plans have received unwarranted payments under this system,  
5 and that the QBP is not a reliable basis for evaluating the  
6 quality of care MA enrollees receive.

7           For instance, star ratings are calculated at the  
8 contract level rather than the plan level. Because  
9 contracts can span multiple, sometimes non-contiguous  
10 markets, these data do not meaningfully reflect the care  
11 received in a local area. Unlike most fee-for-service  
12 quality programs, the QBP is not budget neutral. This has  
13 implications not only for MA benchmarks but also for Part B  
14 premiums for fee-for-service beneficiaries.

15           The Commission has published extensively on this  
16 topic, culminating in a June 2020 recommendation that the  
17 Congress should replace the current QBP with an MA Value  
18 Incentive Program, or MAVIP, to address these and other  
19 concerns. This cycle, we will explore indicators of plan  
20 quality beyond the clinical outcomes and patient experience  
21 measures that we advocated as part of the MAVIP.

22           This fall, we plan to introduce a new framework

1 for evaluating MA plan performance, which includes  
2 traditional quality measures but also considers other  
3 indicators of plan performance. We begin with the  
4 assumption that plans can take actions that influence  
5 quality, access, and cost. We will consider two such  
6 activities in detail, designing provider networks and prior  
7 authorization.

8           We plan to explore the potential impacts of the  
9 use of these tools, both positive and negative, intended  
10 and unintended. We will review current regulations,  
11 guidance, and data reporting on these activities.

12           We plan to discuss the possibility of including  
13 these activities in our evaluation of plan performance  
14 going forward, considering the advantages and limitations  
15 of evaluating plans on these metrics.

16           In the spring, we plan to present two analytic  
17 projects. First, we plan to present a preliminary analysis  
18 of the characteristics of MA plan provider networks. This  
19 may include, for instance, the share of providers in a  
20 local area included in a plan's network, the average  
21 breadth of networks in different service lines, and the  
22 exclusivity for providers shared across plans in the same

1 local area.

2           Second, we plan to compare MA plan performance on  
3 a quality measure we considered as part of the MAVIP,  
4 ambulatory care-sensitive hospitalizations. Consistent  
5 with our earlier recommendation, we plan to score this  
6 measure at the local market level rather than the contract  
7 level, and we will use peer groups to compare across plans  
8 with similar enrollee attributes.

9           Our third June chapter will provide an updated  
10 assessment of the accuracy and completeness of MA encounter  
11 data. While MA plans are required to submit encounter data  
12 about items and services provide to their enrollees, our  
13 prior analyses have found that the data was lacking in both  
14 completeness and accuracy. These data are essential for  
15 calculating and validating the risk scores that are the  
16 basis of MA benchmarks, evaluating the care that MA  
17 enrollees receive, and generating meaningful comparisons  
18 between MA and fee-for-service.

19           The Commission recommended in 2019 that the  
20 Congress should direct the Secretary to establish  
21 thresholds for the completeness and accuracy of MA  
22 encounter data, to rigorously evaluate the quality of data



1 submitted by MA organizations, and to apply a payment  
2 withhold to incentivize compliance.

3           This cycle, we plan to update our assessment of  
4 the completeness of the encounter data, covering dates of  
5 service in 2020 and potentially 2021.

6           While CMS has been collecting encounter data  
7 since 2012, we have consistently found this data to be  
8 incomplete. However, researchers are beginning to use the  
9 encounter data more frequently to study service use in MA.  
10 We plan to include a review of academic literature using  
11 encounter data and to comment on whether and how data  
12 quality is likely to affect the results of such studies.

13           Finally, we plan to compare the utilization data  
14 and plans' bids to the information reported in the  
15 encounter data. Payments to MA plans are based on bids  
16 that plans submit to CMS. Those bids are required to be  
17 based on utilization in a base period, generally two years  
18 prior to the contract year, trended forward to reflect  
19 estimated changes in the cost of providing coverage.

20           Under current bidding guidelines, the utilization  
21 rates reported in the bids should generally be consistent  
22 with the utilization rates calculated using the encounter

1 data. This is important because variability in how  
2 utilization rates are calculated and used for constructing  
3 bids could have implications for competition between  
4 insurers. We plan to assess the extent to which this has  
5 been the case in recent years.

6 This final slide shows a summary of our planned  
7 presentations for this cycle as well as the plan chapters  
8 that they are associated with.

9 We look forward to your feedback on the work plan  
10 as well as to discussing these topics with you in more  
11 detail over the course of the cycle.

12 With that, I'll hand things back over to Mike.  
13 We look forward to your questions.

14 DR. CHERNEW: Katelyn, thank you. Stuart, thank  
15 you. Andy, thank you for just being there.

16 [Laughter.]

17 DR. CHERNEW: That was sincere, actually,  
18 genuinely. In fact, I can tell you, this is not the entire  
19 team of people working on Medicare Advantage. The issues  
20 are actually really important to other people. I'll give a  
21 shout-out to at least Luis and Eric as well, who we're  
22 going to see in a minute.

1           So anyhow, that's great. I am really very  
2 excited. I think we understand how important the Medicare  
3 Advantage program is and how complicated it is and how that  
4 complication changes as it grows. So we're just going to  
5 jump in. At least here, we're just going to go through one  
6 round of the questions, and I think, Scott, you're going to  
7 be up first.

8           DR. SARRAN: Thanks for the presentation.

9           I've got three comments and then a request, and  
10 all of this, everything I'm going to say is around the  
11 specific and considerable unmet needs of the roughly  
12 million to million and a half beneficiaries that live in a  
13 long-term care facility, although these comments could also  
14 apply to the roughly additional million-or-so beneficiaries  
15 who are eligible by virtue of their functional and other  
16 impairments to live in a long-term care facility but are  
17 living in the community.

18           So here's the three comments. First, I think  
19 what's well known to everyone is how frail the segment of  
20 beneficiaries that live in a facility are, and the frailty  
21 can be measured by specific instruments that measure  
22 frailty, HCC scores, ambulatory care-sensitive ED and

1 hospitalization rates, and mortality. And you can look at  
2 mortality over the last many years. We can look at what  
3 happened during COVID. So that's well known.

4           What's well known to everyone who has had a  
5 relative live in a long-term care facility is how poorly  
6 served those beneficiaries are by the current structures  
7 and payment mechanisms of the fee-for-service or  
8 traditional Medicare. The completely separate and perverse  
9 revenue streams have created a series of downstream  
10 businesses that are just antithetical to what we all want  
11 in terms of high-quality patient-centered care.

12           The third comment is what's not well known to  
13 people who haven't spent professional time in the space is  
14 that there is how poorly this population is served by MA  
15 plans, both in terms of the penetration rate of MA in this  
16 population as well as specific focus that essentially is  
17 not there within either community MA or even within broad  
18 D-SNP plans. So that's comments.

19           The request I have is that understanding we've  
20 got a pretty full work plan and what I'm suggesting may not  
21 really be able to be tackled till the '24 to '25 work plan,  
22 but I'd like us to at least tee up these issues by having

1 the following three types of comments appear in -- probably  
2 in the March status report.

3           The first is just simply comment on the  
4 penetration rate of MA in this population. I looked at  
5 that last -- about a year ago. It's dramatically low, and  
6 that data I think is pretty simply available, the  
7 penetration of MA specifically and then of I-SNPs. So just  
8 let's get that comment in there.

9           Second is in this one, I don't think it requires  
10 any particular work. Let's just get a public comment in a  
11 publicly available document that we're preparing on the  
12 frailty and unmet needs of the population. That's easy.  
13 Everybody knows that, but it's worth, I think, stating in  
14 the report.

15           And then third is that there are published  
16 examples of Triple Aim successes of I-SNP programs. Some  
17 of them are very old but reasonably well done work that  
18 I've seen in the past. Let's just reference those so that  
19 collectively we have a picture of, hey, this is a  
20 challenging frail population with specific and considerable  
21 unmet needs, and yet they're not getting the benefit of the  
22 best that MA can deliver, right?

1           And then the last point is but, hey, we have seen  
2 good examples where MA has delivered, because collectively,  
3 I think that then tees up the saying, you know, let's think  
4 about how MA could do a lot towards meeting these unmet  
5 needs.

6           MS. KELLEY: Greg Poulsen is next, and bear with  
7 me for a moment while I find his comment.

8           Okay. Greg's comment: It is important to note  
9 that although Medicare pays MA plans on a capitated basis,  
10 it remains relatively rare for this beneficial payment  
11 mechanism to be applied to delivery systems and providers.  
12 Since these are the folks who make the meaningful care  
13 decisions and especially provide prevention and early  
14 intervention, this significantly impairs many MA plans to  
15 provide value-enhancing care. For those plans that don't  
16 provide incentives to providers to meaningfully enhance  
17 care value, their most powerful mechanism to enhance  
18 financial performance is maximizing coding and risk  
19 scoring, which we will discuss later this afternoon. I  
20 believe this incentive is actively harmful to CMS and  
21 beneficiaries.

22           And I have Brian next.

1 DR. MILLER: Thank you. I just want to echo  
2 Scott's comments about I-SNPs. Frail benes are served very  
3 poorly by fee-for-service, which is not well coordinated.  
4 They fly in and out of the hospital. This fee-for-service  
5 is actually -- I would say functions as a revenue extractor  
6 for that population as opposed to improving their health.  
7 MA plans -- general MA plans often don't do much better, a  
8 little bit better but not much, and so we should spend some  
9 time thinking about what we can use the I-SNP program for.

10 A couple other comments. One is, you know,  
11 people are concerned about consolidation in the plan space.  
12 It's a valid concern. We should think about what are the  
13 barriers to small plan entry. We should spend some time  
14 quantifying what the regulatory barriers are. If you're a  
15 health system and you want to start an MA plan, we should  
16 look at the cost of start-up, the cost of MA plan entry and  
17 also the human capital required.

18 I'm glad we're studying quality. I think one  
19 thing that's unfair is that we do not apply the same  
20 quality measurement system to MA that we do to the fee-for-  
21 service Medicare as a plan. And so I think that we should  
22 look at doing that as we look at our MA plan quality

1 regulation.

2           And then a final comment, I will hope that our  
3 status report will adequately reflect the different ways of  
4 comparing MA and fee-for-service, noting that they have  
5 distinct benefit packages and that MA is actually a bundle  
6 of benefits, and so that we should compare component cost  
7 in addition to statutory program spending in addition to  
8 total cost for the average bene.

9           Thank you.

10           MS. KELLEY: Okay. I now have a comment from  
11 Larry. He's glad that we are devoting so much attention to  
12 MA. He really likes all the specific things the staff are  
13 proposing to do and is very glad that the work plan is laid  
14 out so comprehensively.

15           He would like to see more information on plan  
16 consolidation at a national level and also at some local,  
17 perhaps county level; for example, using HHIs. Can this be  
18 done? The average beneficiary now has 41 plans offered by  
19 eight insurers available in their area and that the number  
20 of plans available to the average beneficiary has more than  
21 doubled in the last five years. But what are the market  
22 shares in terms of the percentage of MA-enrolled



1 beneficiaries in, for example, the three largest plans  
2 nationally and the three largest at a relevant local level?  
3 It would be interesting to see what the bid level of the  
4 largest plan is.

5           It might be useful to have some information at  
6 some point on the extent, if any, to which insurer-acquired  
7 medical groups stop seeing traditional Medicare patients.  
8 Opinions may differ about whether this is a good or a bad  
9 thing, but I think policymakers would like at least to know  
10 what the facts are. It's not all that easy identifying  
11 insurer-acquired groups and the physicians within them, but  
12 one of the faculty at Weill Cornell has done a lot of work  
13 on this.

14           For work on plan networks, it will be very  
15 important to account for the fact that plans' lists of the  
16 physicians and other clinicians who participate in their  
17 networks are often inadequate. This is very important for  
18 beneficiaries.

19           Okay. And I have Stacie next.

20           DR. DUSETZINA: Thank you. I am really excited  
21 about this stream of work, and I'll just focus on two of  
22 the issues that I think are particularly important.

1           The one is the initial discussion of plan  
2 networks and prior authorization and claims denials. I  
3 think this is absolutely critical for thinking about how  
4 well these plans serve beneficiaries.

5           And I think, in some ways, thinking about it from  
6 the aspect of beneficiaries who have serious illnesses is a  
7 really good way to go, because obviously, if you need  
8 highly specialized care, being able to understand if you've  
9 been in MA, have you been able to access that care in real  
10 time and those challenges, we could probably do some really  
11 nice targeted work talking with people who are kind of in  
12 the rarer condition space but really specialized care  
13 needs, because that's what I worry about with MA. It's a  
14 good deal until you can't get access to the network that  
15 you need.

16           So I'm really, really excited to see that  
17 particular piece, and I think the issues around prior  
18 authorization and access to care are great.

19           I will say also, selfishly, as a researcher, I am  
20 very glad you're going down the path of kicking the tires  
21 on the encounter data more. I would say that one thing  
22 that would be really helpful for the field is to understand

1 where there are differences in the quality across the  
2 different types of payments and services. I think that  
3 there is fairly limited literature base, and some of it  
4 suggests that maybe drug claims are captured pretty well.  
5 It would be nice to know from a holistic view where we  
6 could have more confidence or less confidence. And I'm a  
7 stick person when it comes to sticks and carrots as  
8 incentives, and I think we should penalize plans to get the  
9 coding better if it's really lagging behind.

10 But I'm very excited to see this work moving  
11 forward, and thanks to all of you.

12 MS. KELLEY: Robert.

13 DR. CHERRY: Yes. Thank you for outlining this.  
14 I think it's very helpful not only for ourselves but also  
15 those that are listening in to know what we're going to be  
16 focusing on when it concerns the MA plan.

17 I just have a few brief comments. I'm just going  
18 to limit it to the work around quality, and I also want to  
19 get more granular as we start to see the draft chapters  
20 unfold.

21 Some of this does feel a little bit aspirational,  
22 just based on prior work and prior discussions with the

1 Commission, trying to tease out things like HEDIS measures  
2 for special needs population, and even the ambulatory care-  
3 sensitive hospitalizations around congestive heart failure,  
4 diabetes, or asthma can be a little challenging. First of  
5 all, we want to make sure that the data is clean and  
6 actionable and value-added to those that are driving this  
7 work and not burdensome. But I think most importantly. all  
8 of this, I think is closely related to the completeness of  
9 the encounter data.

10           So I definitely strongly support a payment  
11 withhold for those MA plans that are underperforming in  
12 this area, because we're not going to get the quality  
13 measures that we need. Even things that that Scott is  
14 talking about around frailty index won't happen unless that  
15 encounter data is actually complete and we're able to get  
16 data that drives the performance for the beneficiary.

17           So looking forward to seeing more on this in the  
18 coming months. Thank you.

19           MS. KELLEY: Cheryl.

20           DR. DAMBERG: Thank you for laying out the  
21 agenda. It looks like quite a bit of work but all  
22 important areas to be exploring.

1           I had a couple of comments. In the area of plan  
2 networks, one of the things that I'm not sure if it's part  
3 of your work plan in terms of thinking about network  
4 adequacy is, in addition to what Stacie described in terms  
5 of looking at patients who have significant health needs,  
6 is trying to think about distance to patient because we  
7 know there are ambulatory care deserts in this country, and  
8 despite a plan having a particular specialty provider in  
9 their network, it may be very difficult for many of the  
10 beneficiaries in that plan to actually access that provider  
11 due to distance. And this is probably particularly true  
12 for older beneficiaries who may not be able to drive and  
13 rely on public transportation as well as the duals, people  
14 who have lower incomes.

15           I want to plus-one to Larry and thinking about  
16 consolidation in the plan marketplace. I think that that's  
17 critically important for us to keep our eye on.

18           And then the third comment that I will make, it's  
19 more future looking, because I don't know that you can do  
20 it in this cycle. In terms of thinking about how to  
21 evaluate the D-SNPs, a number of states, such as  
22 California, are engaged in waivers, and they are working

1 very quickly to implement the fully aligned plans, and so I  
2 think it would be interesting in time to be able to look at  
3 states and some of the variation across states in terms of  
4 the type of alignment that's going on within the D-SNP  
5 space and its effect on performance.

6 MS. KELLEY: Wayne.

7 DR. RILEY: Thank you, Katelyn, Stuart, and Andy  
8 for laying this out, incredibly important work as we've all  
9 indicated.

10 I have a question about the ethnic, racial, and  
11 geographic penetration of MA plans, and I don't recall ever  
12 seeing any data that lays out MA participants along those  
13 dimensions. What can you say about that? Because it does  
14 then devolve into the later questions we'll have about  
15 quality and access.

16 DR. JOHNSON: I don't think we have those numbers  
17 right here, but that is something we can look into  
18 surfacing at a later date or in one of the chapters.

19 DR. RILEY: Thank you. I do think that would be  
20 valuable to get a clear sense. Even my own family members  
21 have selected MA, but I have no idea how other Black,  
22 Latino, socioeconomic classes have penetrated or selected

1 MA. I think that would be helpful too, in your work, if  
2 that could be weaved in.

3 DR. JOHNSON: Yeah. And on this point, I think  
4 there's -- just a heads-up for the staff team, I think Amal  
5 Trivedi and colleagues have actually published an article  
6 in Health Affairs that instead of just documenting the  
7 share of MA beneficiaries by race, they've actually flipped  
8 it and looked at it by race and said, oh, how is the share  
9 between fee-for-service and MA? And I think that's what  
10 you're kind of getting at. So I think some of that data is  
11 out there. It might not be as up to date as the data that  
12 you all have, however.

13 MS. KELLEY: Tamara.

14 DR. KONETZKA: I want to add a couple notes to  
15 what Scott said earlier, and I agreed with all of that, and  
16 thank you for bringing that up about institutionalized  
17 populations.

18 A couple of things. First, I want to sort of  
19 plus-one your recommendation that we really take a hard  
20 look at how Medicare Advantage could serve those  
21 beneficiaries better. I think that, in many ways, nursing  
22 homes are kind of an outlier and that the momentum has been

1 going in completely the opposite direction, whereas policy  
2 -- payment policy over the past couple of decades has moved  
3 more and more towards sort of bundled payments and  
4 capitated payments in other areas. In nursing homes, we  
5 see -- especially driven by the Medicaid side, but we see  
6 more and more sort of the opposite direction where people  
7 want to tie every payment to individual services for a  
8 variety of reasons. And so I think because of that  
9 momentum, we've sort of left some of these possibilities  
10 unexplored. So I'm really hoping that as we move forward  
11 with these discussions about Medicare Advantage, about D-  
12 SNPs, that we can find room to talk about all the kinds of  
13 SNPs and this population in particular.

14           The other thing I'd say is, unfortunately I feel  
15 like the evidence base for I-SNPs is really, really thin  
16 right now, right? So in working on the National Academies  
17 report in the past couple of years that came out on nursing  
18 home quality, we ended up recommending I-SNPs as sort of  
19 something to look at, but there really wasn't enough of an  
20 evidence base to really say we should move in that  
21 direction. So I'd love to see us do more work to explore  
22 that and see what evidence there is now.



1 Thank you.

2 MS. KELLEY: Amol.

3 DR. NAVATHE: Okay. So I can be brief about mine  
4 too.

5 Thank you for outlining this very comprehensive,  
6 obviously an important an ever-increasing importance area  
7 for us to look at.

8 I just basically wanted to echo a few different  
9 things, trying to reinforce. I agree with Larry. I think  
10 there's a lot of great work here. I think to the extent  
11 that we can, knowing that we have constraints on the amount  
12 of time that we can expend on different things, I think the  
13 plan consolidation piece seems particularly important for  
14 us to understand, especially the dynamics in the markets.

15 I would add to that, to the extent that we could  
16 look at plan variation as well, I think doing some of that  
17 in the context of the benefit design as part of the  
18 standardization work, but I think more generally thinking  
19 about MA plans not as one unit but as some heterogeneity  
20 there, I think, would be helpful.

21 I agree with Scott and Tamara about looking at  
22 the C-SNP in general, so I-SNPs, but if we can explore

1 that, I think that enrollment and C-SNPs obviously is still  
2 growing. So I think that's a moving target a little bit  
3 but nonetheless wanted to put it on the broad radar.

4 And then I just wanted to echo Stacie's comments  
5 around a lot of support for this initial discussion and  
6 work around the networks, authorization, and claim denials.

7 So thanks. Looking forward to all the work.

8 DR. SARRAN: Just a brief comment further  
9 building largely off Stacie's comments on the importance of  
10 segmenting our understanding of the member experience of  
11 beneficiaries who have serious illnesses, because my bet is  
12 if we did an exercise where all of us wrote down what we  
13 want from the MA program in a qualitative way, us and other  
14 thoughtful people, a lot of what people would say is we  
15 want a better experience for beneficiaries with serious  
16 illnesses than they get in the fee-for-service sector.

17 And I bet also if we then push people to -- or  
18 prodded people and said tell me what you mean by better  
19 experience, we'd come up with similar lists -- timely,  
20 seamless, coordinated, goal concordant. And yet we tend to  
21 lump -- we in CMS and everybody else tends to lump  
22 beneficiaries with serious illnesses along with everybody

1 else, and they're really different in what we want from the  
2 MA program and what we potentially can get from the MA  
3 program. People who are the archetypal 65-year-old whose  
4 health just turned Medicare eligible and is healthy, they,  
5 more or less, want a good insurance product, good benefits,  
6 a reasonable transparent network, no burdensome gotcha sort  
7 of prior auths. It's sort of, you know, a continuation of  
8 what they got if they had felt like they had a good  
9 commercial product.

10           Somebody of any age who's dealing, grappling with  
11 a serious illness and trying to coordinate among many  
12 providers and disabilities and multiple challenges, they  
13 want something really different. And I think we do need --  
14 we, us, CMS, everybody -- we need to get smarter about  
15 segmenting how we look at the experience for populations  
16 and then we need to get much tougher, appropriately much  
17 tougher on MA and delivering on that promise.

18           MS. KELLEY: Gina.

19           MS. UPCHURCH: Thank you.

20           Just really to build off what Scott just said, I  
21 was thinking of segmenting by age and making sure we do  
22 that, because I think of people who are clinging to their F

1 supplements, as they're in their mid to late eighties. I  
2 don't know if it's favorable selection to select a Medicare  
3 Advantage plan or fear of leaving your supplement when  
4 you're in it and you're older, an older person. So just  
5 that segmentation certainly about serious illness makes a  
6 lot of sense to me, because we see a lot of people having  
7 to leave and, if they have rights, to get back to a  
8 supplement doing that.

9           The other thing I would just say as we move  
10 forward with discussions about Medicare Advantage plans is  
11 that a lot of consumers depend on the Plan Finder tool to  
12 help them sort through that, so just encouraging us to  
13 understand how that syncs with what we're looking at and  
14 talking about, because there's so many variables going, and  
15 the Plan Finder has gotten a lot better -- we just need to  
16 keep an eye on the Plan Finder -- to show meaningful  
17 differences to people over time. So I think we keep an eye  
18 on that.

19           And lastly, just importance of not just looking  
20 at encounter data, which is, you know, we need that for  
21 Medicare Advantage plans, but looking at outcomes and  
22 patient satisfaction, caregiver satisfaction, experience

1 with Medicare Advantage as well as traditional Medicare, I  
2 think that's really critical. Morbidity as well as  
3 mortality, obviously.

4 Thanks.

5 MS. KELLEY: Betty.

6 DR. RAMBUR: Thank you.

7 I just wanted to voice my strong support for this  
8 work and the ideas that the Commissioners have put forward.

9 In terms of my priorities, there's so many, but  
10 network adequacy is really high on my list. As Stacie  
11 said, it's great till it's not.

12 Consolidation. The issues of breaking or looking  
13 at this more by race, ethnicity, vulnerable populations,  
14 the frail, and then the ability to deliver on the promise  
15 is really important.

16 And then just to pile on Gina's comment, the  
17 outcome data including patient and provider satisfaction,  
18 we know we have sort of a crisis at the bedside, and so  
19 understanding provider satisfaction as well as patient is  
20 really important.

21 So thank you, and I look forward to continuing to  
22 work with all of you on this.

1 MS. KELLEY: Okay. I have a comment from Kenny.  
2 I believe this is the last --

3 DR. CHERNEW: We are basically at time. So why  
4 don't you read Kenny's, and then I'll wrap up.

5 MS. KELLEY: Okay.

6 Kenny says thank you for highlighting the  
7 rigorous work plan on MA, and he looks forward to the  
8 various discussions in the current cycle.

9 He wishes to pile on Scott, Tamara, and Brian's  
10 comments on more analyses on I-SNPs and wants to echo  
11 support for Amol and Larry to analyze the impact of  
12 consolidation as part of the various analyses.

13 DR. CHERNEW: Okay. So thank you all. There's  
14 obviously a lot to do, and we will have time to talk about  
15 all of these things as the particular chapters that were  
16 just discussed get discussed. So I will avoid some of the  
17 specifics.

18 I do want to just set expectations and say two  
19 things. The first is across these chapters, with the  
20 potential exception of benefits standardization, we're not  
21 going to think through a bunch of new recommendations. A  
22 lot of this is measurement issues, tracking issues,

1 thinking about things like that. We have a set of  
2 recommendations there. And again, that doesn't mean we  
3 will not have recommendations as we move forward in time,  
4 but at least this cycle, we're not contemplating big  
5 changes to what our recommendations are.

6           The second thing that's important, just to  
7 understand that given the scale and magnitude of MA, MA  
8 comes up in a number of things that are not in MA chapters,  
9 and I think that's one thing we missed. We will see MA in  
10 the hospital chapters, in the SNF, in anything we say about  
11 rural stuff. MA is a big deal now of everything. You  
12 could take any talk you care about and say, oh, and how's  
13 that impacted by MA?

14           And the last point, which I think I heard loud  
15 and clear, which I will say now since this it's the first  
16 meeting of the year and bears repeating, is that our sort  
17 of North Star principle is to make sure that Medicare  
18 beneficiaries are well served in a fiscally responsible way  
19 by the Medicare program, and as the Medicare program  
20 becomes more heavily penetrated by MA, all the issues  
21 around beneficiary experience, access, quality of care is  
22 important, understanding -- I just want to make one last

1 point before we break for a few minutes and we move on to  
2 the next topic, which will be MA -- I'm going to practice  
3 that sentence in the mirror since I think I'll say it a lot  
4 -- is that one of the core challenges is how we move to  
5 some of the things that benefits beneficiary experiences  
6 and outcomes.

7 I believe -- I will speak for me; I won't speak  
8 for the Commission. I believe that there are  
9 inefficiencies in the traditional Medicare program that  
10 Medicare Advantage can reduce. So just because the  
11 networks aren't fully broad or because there's prior auths  
12 or other things doesn't inherently mean Medicare Advantage  
13 is performing poorly.

14 The challenge is to make sure that when those  
15 things are imposed, they are not excessively imposed in a  
16 way that is causing undue harm to beneficiaries and  
17 accessing, their experience, things like that. Therein  
18 lies the challenge is that by definition we need these  
19 plans to accomplish what we'd like them to accomplish. We  
20 need to make sure that they do that in a way that is  
21 suitable and that we pay them a reasonable amount to do it.

22 So that's where I am on this. We are going to



1 see a lot of this, the status chapter. The MA status  
2 chapter carries a lot of weight, but you're going to see a  
3 bunch of other tracking data things, and you will see MA  
4 and MA-related issues come up throughout almost everything  
5 we do now.

6 So I'm going to do this. All right. So we're  
7 going to take a five-minute break, and then we're going to  
8 come back. And we will be talking about standardization of  
9 benefits in Medicare Advantage plans with Eric. So see you  
10 all in five minutes.

11 [Recess.]

12 DR. CHERNEW: We're back, and this is a  
13 continuation of a really complicated topic, that the more  
14 you scratch the surface, the more you realize issues arise.

15 So, Eric, we're going to turn it to you to take  
16 us through this, and then we can have a discussion and  
17 understand that we are thinking through exactly the pace  
18 with which we want to go -- the substance and the pace with  
19 which we want to go through all of this. So, Eric, go  
20 ahead.

21 MR. ROLLINS: Thank you.

22 Last year, the Commission began examining the use

1 of standardized benefits in MA plans, and we included an  
2 informational chapter on the topic in our June 2023 report  
3 to Congress. Today we're going to resume our work on  
4 standardized benefits by reviewing some key points from  
5 last year's work, providing some additional information,  
6 and continuing your discussions about potential policy  
7 options for standardizing benefits. Our goal today is to  
8 determine whether you are interested in pursuing a  
9 recommendation on the use of standardized benefits during  
10 this meeting cycle.

11 Before I begin, I'd like to remind the audience  
12 that they can download these slides in the handout section  
13 on the right-hand side of the screen.

14 As of this year, a majority of beneficiaries with  
15 Part A and Part B coverage are enrolled in Medicare  
16 Advantage plans. The average beneficiary now has 41 plans  
17 available in their area, and the number of plans available  
18 to the average beneficiary has more than doubled in the  
19 last five years.

20 Health plans can differ in many respects, and  
21 researchers have found that individuals have more  
22 difficulty comparing plans and deciding which one best

1 meets their needs when they are faced with many choices.  
2 For example, they might end up enrolling in a plan where  
3 their out-of-pocket costs are higher than they would be in  
4 other plans.

5 MA plans are difficult to compare because  
6 insurers have a lot of flexibility in how they design their  
7 plans. In our work last year, we found substantial  
8 variation across plans in the cost sharing they charge for  
9 Part A and B services, where plans can develop their own  
10 cost-sharing rules and charge lower amounts than  
11 traditional Medicare as an extra benefit, and in their  
12 coverage of supplemental benefits where plans can cover a  
13 wide variety of items and services that traditional  
14 Medicare does not cover, such as gym memberships, dental  
15 benefits, or over-the-counter items. These features play a  
16 key role in attracting enrollment and are largely financed  
17 by the rebates that plans receive under the MA payment  
18 system.

19 One way to make it easier for beneficiaries to  
20 compare plans would be by requiring plans to have  
21 standardized benefits. This approach would give  
22 beneficiaries a more clearly defined set of choices and,

1 thus, could improve competition among plans. As we  
2 discussed in your mailing materials, standardization has  
3 been used in both the Medigap market and the ACA's health  
4 insurance exchanges.

5 For MA plans, the Commission is focused on  
6 standardizing cost-sharing amounts for Part A and B  
7 services and supplemental benefits. Although  
8 standardization would make it easier to compare plans, it's  
9 worth noting that plans would still vary in important ways,  
10 such as their provider networks and drug formularies.

11 So now I'm going to shift gears and talk about  
12 two topics where Commissioners asked for more information  
13 during the last meeting cycle. I'm going to go through  
14 these somewhat quickly, but there's more information in  
15 your mailing materials, and I'm happy to discuss them on  
16 question.

17 First, Commissioners wanted a better  
18 understanding of the factors behind the growth in the  
19 number of MA plans which, as I noted earlier, has more than  
20 doubled in the last five years.

21 This graphic shows the cumulative percentage  
22 change between 2013 and 2023 in three metrics: one, the

1 average number of plans available to beneficiaries; two,  
2 the average number of insurers offering plans; and three,  
3 the average number of plans offered by each insurer.

4           As you can see, these metrics were basically flat  
5 during the first half of this period but grew steadily  
6 starting around 2018 or 2019. By 2023, the average number  
7 of insurers had increased by 43 percent, while the average  
8 number of plans offered by each insurer had increased by 53  
9 percent. The combination of these two factors led to rapid  
10 growth in the number of plans, which jumped by 119 percent.

11           We believe that the growth in the number of  
12 insurers is likely due to the generous plan payment rates  
13 and overall profitability of the MA program. We found this  
14 growth has been primarily driven by the major publicly  
15 traded insurers, which already offered MA plans in 2018 but  
16 have since expanded into new geographic markets rather than  
17 the entry of new insurers.

18           As for the number of plans per insurer, we  
19 believe the recent growth is likely due to the elimination  
20 of a requirement that MA plans offered by the same insurer  
21 in the same market must have meaningful differences. This  
22 change took effect in 2019 and was noted on the graphic we

1 just saw. Since then, the average number of plans offered  
2 by the same insurer in the same county has risen from 3.3  
3 to 5.1, and some insurers now offer more than 10 plans in  
4 some counties.

5           There has been particularly rapid growth in the  
6 number of PPO-style plans, which provide some coverage for  
7 out-of-network care.

8           The other topic where Commissioners asked for  
9 more information was the variation in MA benefits. In our  
10 work last year, we analyzed the variation in benefits using  
11 data for all conventional plans, regardless of their  
12 service area, and Commissioners wanted to know if the  
13 variation we observed at the national level also existed  
14 when looking at plans offered in the same local market.

15           To address this question, we used individual  
16 counties as local markets since the service areas for most  
17 plans are defined at the county level. We found  
18 substantial variation across plans in areas like the  
19 maximum out-of-pocket limit, cost sharing for an inpatient  
20 stay, and dental benefits. In addition, we found variation  
21 regardless of whether the county had a low, moderate, or  
22 high number of plans.

1           That said, there were also features that didn't  
2 vary much across the plans in a given market, like primary  
3 care visits, where most plans do not charge cost sharing.

4           Our analysis was somewhat limited in scope, but  
5 it suggests that substantial variation in cost sharing and  
6 supplemental benefits is present in many local markets.  
7 The use of standardized benefits could, thus, make it  
8 easier for beneficiaries throughout the country to compare  
9 MA plans.

10           So now we're going to talk about some potential  
11 policy options for standardizing MA benefits. Last year,  
12 the Commission had some initial discussions about these  
13 options, and there appeared to be broad agreement that any  
14 effort to standardize benefits would need to differentiate  
15 between three types of benefits: cost sharing for Part A  
16 and B services; dental, hearing, and vision benefits; and  
17 finally, all other supplemental benefits.

18           A recurring theme in these discussions,  
19 particularly for supplemental benefits, was an interest in  
20 balancing the competing goals of making it easier for  
21 beneficiaries to distinguish among plans with giving plans  
22 enough flexibility to develop different benefit designs.

1           For Part A and B services, standardization would  
2 only affect enrollee cost sharing since all MA plans are  
3 required to cover the same services here. Here, the  
4 Commission focused on an approach similar to the Medigap  
5 and ACA markets that would require plans to use a limited  
6 number of benefit packages that specify the plans out-of-  
7 pocket limit and cost-sharing amounts for all major  
8 services.

9           Since MA rebates and benefits vary  
10 geographically, the use of multiple benefit packages would  
11 preserve some degree of choice for beneficiaries and would  
12 help to accommodate the regional variation that exists in  
13 MA rebates and benefits.

14           This table, which appeared in our June report,  
15 provides some purely illustrative benefit packages to give  
16 you a sense of how this approach would work. In this  
17 example, there are three benefit packages: lower  
18 generosity, medium generosity, and higher generosity. The  
19 more generous packages would have lower out-of-pockets, the  
20 pocket limits, and lower cost sharing for many services.

21           While these benefit packages are illustrative,  
22 their parameters are based on the current cost-sharing



1 rules for conventional MA plans. Since most plans use  
2 rebates to reduce Part A and B cost sharing, enrollees  
3 would pay less in cost sharing, at least in aggregate,  
4 under each package than they would in fee-for-service.

5 We should also note that any actual benefit  
6 packages would likely include a wider array of services  
7 than the subset shown here.

8 With respect to supplemental benefits, the  
9 Commission viewed dental, hearing, and vision benefits as  
10 good candidates for standardization since they are covered  
11 by almost all plans, at least to some extent, are often  
12 highlighted in plan marketing efforts, and their parameters  
13 often vary across plans.

14 One approach that would achieve a high level of  
15 standardization for these benefits would be to give plans a  
16 limited number of options for covering them. These would  
17 essentially be benefit-specific versions of the standard  
18 packages that we just saw for Part A and B cost sharing.

19 Each option would specify the benefits coverage  
20 limits, cost-sharing rules, and per-enrollee spending  
21 limit. These requirements would apply only to plans that  
22 chose to provide dental, hearing, and vision benefits.

1           In contrast, Commissioners generally agreed that  
2 the current rules for all other supplemental benefits would  
3 remain the same to preserve plans' flexibility to develop  
4 different benefit designs. Plans would still be able to  
5 provide the same benefits they do now, including benefits  
6 that are not primarily health related, and could still  
7 target those benefits to certain types of enrollees.

8           This table, which also appeared in our June  
9 report, provides a purely illustrative example of some  
10 standardized options for dental benefits. This example is  
11 based partly on current MA dental benefits and partly on  
12 the stand-alone dental plans offered to federal employees.

13           In this example, conventional plans that wanted  
14 to offer dental benefits would have only two choices, a  
15 standard option and a high option. Both options would  
16 cover the same services and have the same coverage limits.

17           Similar to existing MA dental benefits, both  
18 options would have no deductible, no cost sharing for  
19 preventive services, and a maximum co-insurance rate of 50  
20 percent for major services. However, the high option would  
21 clearly be more generous, with lower cost sharing and a  
22 higher annual limit.

1           There could also be separate options for special  
2 needs plans that have higher annual limits and no cost  
3 sharing, since these plans typically have more generous  
4 benefits than conventional plans.

5           Although the Commissioners agreed on some aspects  
6 of how MA benefits might be standardized, there are other  
7 important issues to consider. Last year, we identified  
8 three issues in particular. First, which types of MA plans  
9 would be standardized? Second, would insurers still be  
10 able to offer non-standardized plans? And third, how many  
11 standardized plans could each insurer offer? The  
12 Commission's discussions of these issues were preliminary,  
13 since our work on standardized benefits was at an early  
14 stage.

15           For the first issue, which types of MA plans  
16 would be standardized, it's helpful to divide plans into  
17 three separate groups. The first group are conventional  
18 plans, which account for 64 percent of MA enrollment. We  
19 think they are the most logical candidates for  
20 standardization since they are available to all  
21 beneficiaries who have Part A and B coverage and live in  
22 the plan service area.

1           The second group of plans are special needs  
2 plans, which serve beneficiaries who receive Medicaid, need  
3 long-term care, or have a specific chronic condition.

4           SNPs account for 19 percent of MA enrollment. We  
5 think the rationale for standardizing Part A and B cost  
6 sharing is weaker for these plans because Medicaid covers  
7 those costs for most enrollees. Policymakers may also want  
8 to give SNPs more flexibility given their focus on  
9 populations with distinctive care needs. Having said that,  
10 policymakers could consider requiring SNPs to standardize  
11 their dental, hearing, and vision coverage.

12           The third group of plans are employer-sponsored  
13 plans, which account for 17 percent of MA enrollment.  
14 Policymakers may want to exclude these plans from  
15 standardization because their enrollees typically have a  
16 more limited and presumably a more manageable number of  
17 coverage options compared to beneficiaries enrolling in  
18 conventional plans.

19           The second issue is whether insurers would be  
20 required to use standardized benefits in all plans.  
21 Allowing insurers to offer both standardized and non-  
22 standardized plans would reduce disruption for existing MA

1 enrollees, but it could actually make the plan selection  
2 process more difficult because there would be more choices  
3 to navigate.

4           Alternatively, requiring all plans to have  
5 standardized benefits would do more to simplify the plan  
6 selection process but what initially caused some disruption  
7 for enrollees as plans modified their designs to meet the  
8 new requirements.

9           However, it's worth keeping in mind that the MA  
10 program already generates some disruption for enrollees  
11 when plans make year-to-year changes in their benefit  
12 designs. If all plans were required to have standardized  
13 benefits, the transition could be implemented in several  
14 ways that are discussed more in your mailing materials.

15           The third issue is how many standardized plans  
16 each insurer would be able to offer, which would affect the  
17 overall number and variety of plan choices. We think the  
18 total number of plans per insurer would depend on several  
19 factors. One would be the number of distinct benefit  
20 packages that insurers could use in their plans. A larger  
21 number of packages would give beneficiaries more choices,  
22 but it might not make it that much easier for them to

1 compare plans.

2           In addition, if there were distinct benefit  
3 packages for Part A and B cost sharing and for dental,  
4 hearing, and vision benefits, which is the approach that  
5 the Commission appeared to favor in last year's  
6 discussions, another factor would be how insurers combine  
7 those packages. For example, using the illustrative  
8 examples I just showed you, could an insurer offer three  
9 plans with the same Part A and B cost sharing, one with no  
10 dental coverage, one with standard dental, and one with  
11 high dental, or could an insurer offer just one plan for  
12 each package of Part A and B cost sharing?

13           Finally, could insurers offer plans that have the  
14 same benefit package but different types of provider  
15 networks? For example, could insurers offer HMO and PPO  
16 versions of the same benefit package? With  
17 standardization, this would mean that both plans have the  
18 same cost sharing for in-network care, but the PPO would  
19 provide some coverage of out-of-network care, while the HMO  
20 would not.

21           These parameters all interact, and relatively  
22 small changes to them could have a significant effect on

1 the overall number of plans available to beneficiaries.  
2 For example, if there were two benefit packages and two  
3 types of provider networks, insurers could offer up to four  
4 plans in a market, and an area with eight different  
5 insurers, which is the current MA average, would have as  
6 many as 32 plans. Adding a third benefit package would  
7 mean that the same area might have as many as 48 plans.

8           That brings us to the discussion. We would like  
9 to know if you are interested in pursuing a recommendation  
10 on standardized benefits in MA plans. If the answer is  
11 yes, we will come back to you in January to lay out some  
12 policy options.

13           In addition, if you are interested in pursuing a  
14 recommendation, we'd like your feedback on the three issues  
15 I just outlined: which types of plans should be  
16 standardized, whether insurers could still offer non-  
17 standardized plans, and how many standardized plans each  
18 insurer would be able to offer.

19           That concludes my presentation, and I'll now turn  
20 it back to Mike.

21           DR. CHERNEW: This slide woke me up.

22           So, Eric, thank you. There's a lot here.

1           I want to say a few things before we jump into  
2 Round 1 to sort of lay some groundwork so we aren't just  
3 talking past each other. So hopefully, this will be  
4 helpful. We will see.

5           So there's three problems that I think different  
6 folks are sometimes trying to solve the different problems.  
7 One problem is there's just too many plans. They're  
8 overwhelmed. There's just too many plans to choose from.  
9 Another problem is it's not the number of plans. It's all  
10 those plans differ in a whole bunch of different ways. So  
11 it's just that -- we could deal with 85 plans if we really  
12 didn't have that variable between them. And then the third  
13 problem is we could deal with a lot of really different  
14 plans. The problem is really one of transparency. The  
15 plan says it offers dental, but does it really offer  
16 dental? And those are different problems that I suspect  
17 you will comment on them, but how we treat them in the  
18 recommendation or where we go will matter as to which ones  
19 we emphasize, what we try to do.

20           And to put a little concreteness behind that,  
21 imagine for a moment we standardized within categories. So  
22 now dental was standardized. Vision was standardized. We



1 had all these different categories, right? We could allow  
2 different combinations of those things. We could say if  
3 you're going to offer them, these are what they are, but  
4 offer as many different combinations as you want. You  
5 could still have a huge number of plans, but you would know  
6 what any particular thing was.

7 Or we could -- CMS could limit the combinations  
8 like they do in Medigap, where we pick. You're generous,  
9 and so you're generous on vision and dental and hearing.  
10 We don't let you mix and match. We pick a much more  
11 specific set of things, and so that's constraining at some  
12 level.

13 Or we could say we'll let you choose whatever  
14 combination you want, but any given carrier can pick a  
15 limited number of plans. So we're going to control the  
16 number of plans by saying a carrier can pick a certain set  
17 of -- whatever they want. Standardized vision, dental,  
18 hearing, all could be different, but they only get three  
19 plans. Pick which ones you want. And those are all  
20 different versions, depending on which problem you think  
21 we're trying to solve that is, and there's important -- so  
22 I think one of the challenges here is for whatever we

1 decide, there's potential unintended consequences for how  
2 competition and other things work, particularly when  
3 there's going to be non-standardization on other aspects of  
4 the plans, the network, the Part D stuff.

5           We're never going to get -- unlike Medigap where  
6 you can standardize most things, we're not going to get  
7 there here, and that is hard.

8           On the plus -- and that was not meant to be  
9 intimidating. On the plus side, the recommendation does  
10 not have to be granular, and since this is the first  
11 meeting, I will say there is a distinction between the  
12 recommendation and the policy options. So some of the  
13 answers to these questions, which are great questions, they  
14 can be dealt with in the policy option, but we don't  
15 actually have to have a recommendation that specifies the  
16 answer to every one of the questions that Eric laid out,  
17 but to do our policy option, we need more specificity than  
18 the recommendation may, in fact, entail. So it's not just  
19 should there be a recommendation. It's how specific should  
20 it be. Where do we go?

21           So I know we're going to start Round 1 in a  
22 second, but I'm interested in understanding part of the

1 problem you think is the biggest, how you feel about the  
2 questions Eric laid out, and how you feel we should address  
3 the different parts of that problem.

4           So, with that said, I think Cheryl is the first  
5 person in Round 1. Cheryl.

6           DR. DAMBERG: Thanks.

7           I had two questions. So on slide 5, which is  
8 figure 1 in our draft, one of the lines refers to the  
9 number of plans offered by insurers is growing, and I was  
10 curious. Are you able to break out to what extent they're  
11 offering new plans in new markets, and are those markets  
12 that are highly concentrated, so maybe it's introducing  
13 more competition into those markets versus they're just  
14 offering more multiples in the same markets that they've  
15 historically been in? So just trying to understand whether  
16 we can have a little more granularity.

17           MR. ROLLINS: I don't have specific numbers at  
18 hand. I think you are seeing both. Plans are offering  
19 more -- the insurers are offering more products in the  
20 areas that they already served previously, and they are  
21 entering new markets they didn't serve before.

22           We had some -- a short discussion of sort of

1 concentration in our March 23 MA chapter, and what we had  
2 found was that at the national level, you see a fairly high  
3 amount of concentration, but when you look at sort of the  
4 local, like county level, like what share of enrollment is  
5 clustered in the top two or three insurers, that's been  
6 going down somewhat modestly over time. And I think it's  
7 related to what we talked about more in the mailing  
8 materials, that a lot of your sort of large for-profit  
9 insurers are expanding their MA footprint and entering  
10 markets where previously it might have been more  
11 concentrated perhaps. You had sort of like a regional  
12 insurer that had a larger market share.

13 DR. DAMBERG: And do you also know whether  
14 they're entering areas where there historically hasn't been  
15 much MA penetration at all?

16 MR. ROLLINS: Off the top of my head, I don't  
17 know that. That would be my intuition is they've started  
18 with the most favorable areas and have been sort of  
19 branching out since then, but I don't have data at hand to  
20 answer that.

21 DR. DAMBERG: Okay. Thanks.

22 And then my second question was on figure 5, and

1 I found that graphic super interesting, that I was curious.  
2 Does this commingle HMO and PPO plans?

3 MR. ROLLINS: It's based on all conventional  
4 plans in the market. So it includes both HMO-style  
5 products and PPO-style products.

6 DR. DAMBERG: Yeah. So I'm, again, wondering  
7 whether maybe splitting it out by those different plan  
8 types might be helpful just in terms of understanding the  
9 distribution or the range of different benefit packages  
10 within those types of plans.

11 MS. KELLEY: Amol.

12 DR. NAVATHE: Thanks, Eric. Great work, great  
13 chapter write-up, very clear.

14 I had, hopefully, what is a relatively quick  
15 question. So in the mailing materials on page 6, you had  
16 noted that there are some cost-sharing limits that MA plans  
17 have to follow, and that plans cannot charge more in cost  
18 sharing than fee-for-service for some services. You noted  
19 inpatient care, SNF, dialysis, et cetera. And then there  
20 are other services, notably physician services, where plans  
21 can charge more than fee-for-service, but there's still a  
22 limit. And I was curious what that limit is, even if it's

1 above fee-for-service. Do you have a sense of what that  
2 is?

3 MR. ROLLINS: So specifically for physician, it  
4 is tied to where your out-of-pocket limit is set, and CMS  
5 has sort of delineated three ranges for your out-of-pocket  
6 limit. So it can range all the way -- it can be zero, but  
7 it can range as high as \$8,300. And CMS has essentially  
8 cut that dollar range into three pieces, sort of low, what  
9 they call a low out-of-pocket limit -- I forget the term,  
10 but basically low, medium, and high out-of-pocket limits.

11 And for a physician, I think the limit is for the  
12 -- if you have the lowest out-of-pocket limit, they can  
13 charge up to the equivalent of 50 percent coinsurance. For  
14 the middle one, I want to say it's 40 percent, and for  
15 plans that use the highest limit, I think it's 30 percent.  
16 So the limits are set up to basically say -- to create a  
17 tradeoff for plans, that if you have a lower out-of-pocket  
18 limit, we will give you a little more latitude on the cost  
19 sharing you charge for sort of individual services.

20 DR. NAVATHE: Got it. Super helpful. Thanks.

21 MS. KELLEY: Brian.

22 DR. MILLER: Thank you.

1           Very interesting chapter and a great slide deck.

2           One response and then two comments. The response  
3 is when we're talking about insurer consolidation, if we  
4 look at the Aetna, Humana DOJ case, the appropriate  
5 geographic market for measuring market concentration for MA  
6 is the county level. It sits with the antitrust community  
7 types of things, so we should probably follow that.

8           The 21-flavor-peanut-butter problem, as I call  
9 the MA plan choice, is something which there is an  
10 extensive marketing literature on in the management of  
11 business community. I think we should look to that for  
12 guidance.

13           For complex markets with information asymmetries,  
14 in the 21st century, we have other filters that we use to  
15 handle overwhelming choice. Examples that I think are  
16 Zillow for home purchases, Booking.com for the thousands of  
17 hotels, which we can never figure out, and then if you want  
18 to go to classic cars even, an even harder market, Bring-a-  
19 Trailer. And so I think we should start to think through  
20 the overwhelming choice lens through the filter of that  
21 choice, and we should add discussion about that.

22           In that vein, my view is that the discussion of

1 Medigap on pages 2, 3, 25, 26, and 30 is somewhat dated  
2 because the standardization occurred when people did not  
3 have easy access to information or an ability to filter it.  
4 So my thought is we should eliminate the Medigap example.

5 MS. KELLEY: Gina.

6 MS. UPCHURCH: Thank you.

7 I found myself writing yes in the commentary to  
8 your chapter, so well done. Thank you.

9 Just a quick question -- two questions. On page  
10 18, when you're talking about Medicare Advantage plans,  
11 medical-only Medicare Advantage plans, you mentioned that 4  
12 percent of them have stand-alone drug plans also. I didn't  
13 think that was allowed. Is that newly allowed that you  
14 could be in an MA-only and a standalone drug plan also?

15 MR. ROLLINS: I didn't look into it closely. It  
16 did have me scratching my head a little bit.

17 MS. UPCHURCH: Yeah. I don't --

18 MR. ROLLINS: It was a little unclear how that  
19 happens.

20 MS. UPCHURCH: Okay. It used to not be allowed.  
21 So I'm not sure. If we could just clarify that, that was  
22 one question.



1           And I can't remember what the other question is.  
2       So we'll stick with that one. Thank you.

3           MS. KELLEY: That's all I have for Round 1.

4           DR. CHERNEW: That was all I had for Round 1 as  
5       well, but there's a lengthy Round 2 queue. So we will be  
6       watching the time, and please watch the time of your  
7       comments.

8           The first person is going to be Jonathan, if I  
9       have that correct.

10          DR. JAFFERY: Thanks, Mike. And yeah, thanks,  
11       Eric. This is a great chapter. I was excited about the  
12       conversation last year and very excited about continuing to  
13       have it now, and I love the way you laid out how we reached  
14       certain levels of agreement, but need to take this to the  
15       next step now.

16          A couple years ago, my niece got her first job  
17       where she was picking her own insurance, and she happened  
18       to work for a place that was -- that had many, many, many  
19       options, and so she called me to see if I could help her  
20       work through it. And so I was asking her for -- I was  
21       trying to understand what was most important to her about -  
22       - you know, she's looking at all these premiums are

1 different, but cost sharing is different and blah, blah,  
2 blah. And at the end, she said, "Well, I just want to pay  
3 the least amount at the end of the year." I was like,  
4 "Well, yes, that's what everybody wants."

5 [Laughter.]

6 DR. JAFFERY: And so I think, to me, this is much  
7 -- you know, thinking about Brian's comment, like this is  
8 different than rent, booking a hotel, right? You sort of  
9 know what you're looking for today. You can see the cost  
10 up front, and I think it's clear that the choices are just  
11 overwhelming for people.

12 So I think, to me, the biggest problem that we're  
13 trying to solve really is this intersection of there's just  
14 too many choices for people, and it's too difficult to  
15 understand what benefits are actually offered, even if  
16 we're never going to get to the point where you know  
17 exactly what sort of utilization you're going to need on  
18 January 1st or whenever -- November 1st or whenever you're  
19 picking.

20 I actually think the Medigap example is a good  
21 one, and it was interesting. I knew that we had gone from  
22 ten to eight or -- although I think some are grandfathered.

1 So they are probably still ten out there. I can't remember  
2 the exact numbers, but in the chapter, some significant  
3 percentage, I believe, is only for three of those plans.  
4 So I think that really shows you that we can narrow this  
5 down and still give people the choices that they need.

6 So I would very much favor, first of all, coming  
7 up with a limited number, and I don't know what that number  
8 is. I had written down while I was going through the  
9 chapter, less than eight or less than equal to eight. But  
10 that's not based on anything in particular than the Medigap  
11 stuff.

12 To get to some of your questions, I think that it  
13 clearly makes sense that what we talked about, I continue  
14 to believe what we talked about last year, that the dental,  
15 vision, and hearing as well as A and B are the things that  
16 can and should be standardized, and that would be a nice  
17 balance for plans to be able to continue to innovate around  
18 these other things, which I think you mentioned aren't  
19 really benefits for health, and I think -- or aren't really  
20 health benefits. And I would modify that to say they're  
21 not health care benefits. Hopefully, they're still only  
22 offering things that relate to health, even if they're not

1 traditional things.

2 I think the question about could insurance still  
3 offer non-standardized plans, to me, that sort of defeats  
4 the whole purpose. So I would say no.

5 And I guess I'll leave it at that and let others  
6 comment. Thanks.

7 MR. ROLLINS: Jonathan, can I ask one clarifying  
8 question?

9 DR. JAFFERY: Sure.

10 MR. ROLLINS: And this is not -- nobody needs a  
11 lawyer or anything. When you said less than eight, are you  
12 thinking about that as total for the market or per insurer?

13 DR. JAFFERY: The market.

14 MR. ROLLINS: Okay.

15 DR. JAFFERY: So similar to the Medigap.

16 MR. ROLLINS: Gotcha.

17 DR. JAFFERY: Yeah.

18 MR. ROLLINS: That's helpful. Thank you.

19 DR. CHERNEW: So there's 1 other thing that I  
20 want to ask about that. Let's see if I can set frame this  
21 well. You could not allow deviations from benefit  
22 categories that we standardized and still allow some aspect

1 of non-standardization amongst the plans, if that makes  
2 sense. In other words, if you offer dental, you have to  
3 offer one of our several dental things, but we could allow  
4 some of the supplemental benefits to vary in other ways. I  
5 just want to make sure that it's -- so there's another  
6 version which is you try your best to standardize those  
7 things. I don't think that's what you meant.

8 DR. JAFFERY: Right. No. Thank you for that.

9 So when I was saying that we shouldn't offer non-  
10 standardized, I did not mean that. I still think that  
11 there's that area for innovation outside dental, vision,  
12 and hearing in A and B, but I guess that I was interpreting  
13 that as could people still offer things that were all of,  
14 you know --

15 MS. KELLEY: Jaewon.

16 DR. RYU: Yeah. Thank you, Eric. I also really  
17 thought the chapter does a good job laying out a lot of  
18 information.

19 I think, like most things, this strikes me as a  
20 balancing act, and I think your slide 8 lays out that  
21 balance pretty well. If anything, I would have a little  
22 bit of an overlay on that slide by saying that really plan

1 design, it either creates an environment where you can have  
2 the right care approach for -- that works for the right  
3 kind of beneficiary, or it could create an environment that  
4 makes it really challenging to get to that right care  
5 approach for a given beneficiary.

6           So I think we want to be a little careful in  
7 terms of how to strike the balance to make sure that we're  
8 not curtailing innovation, especially in areas or in  
9 populations that may need very different care models, and  
10 so that is why I was really happy that you had mentioned  
11 the SNP plans, because I think that is a good example of  
12 where standardized benefits -- it feels more challenging in  
13 that setting versus, I think, what you called the  
14 "conventional MA plans."

15           I think the illustrative packages, I like them.  
16 I agree with Jonathan and others around the dental,  
17 hearing, and vision. I think that's a really ripe area for  
18 standardization, and to probably a slightly lesser degree,  
19 I think A and B. But I do like the illustrative packages  
20 that you laid out.

21           I think the supplemental is the one I feel least  
22 comfortable with standardizing, but I think what I found

1 even more compelling was you had some commentary on page 4  
2 of the readings around the exchange experience. And I  
3 think that combination of limiting the number of offerings  
4 per carrier -- and I think there was a rule where if you  
5 were to offer a non-standard plan, you had to offer a  
6 standard plan -- and at the same time, having some degree  
7 of standardization around the categories and packages, I  
8 thought that was a really nice blend and a combination. So  
9 I probably gravitate a little bit to a model that looks  
10 like that.

11 MS. KELLEY: Okay. I have a comment from Kenny.  
12 Kenny says thanks, Eric, for the intellectually stimulating  
13 piece on this complex standardization topic. He has three  
14 observations, which are best summarized by the three C's:  
15 CMS, competition, and conventional plans.

16 First, CMS. What is the problem that we are  
17 trying to solve? Is it one of simplification to mitigate  
18 the choice conundrum for beneficiaries? For CMS, it is to  
19 increase competition by eliminating meaningful difference  
20 to promote healthier competition and innovation. New  
21 flexibilities in benefit design and more sophisticated  
22 approaches to consumer engagement and decision-making

1 should help beneficiaries, caregivers, and family members  
2 make more informed plan choices.

3           Secondly, competition. He realizes that we are  
4 in an early phase of this analysis. He would like to  
5 emphasize, though, that unless this is implemented  
6 thoughtfully over at least two cycles, he believes  
7 imprudent standardization would likely reduce competition.  
8 Any imprudent standardization proposal for new plans could  
9 increase the administration burden to plans. When this  
10 occurs, small plans could drop out due to lack of scale,  
11 and the big plans win. And while we could solve the choice  
12 conundrum for 2 million annual new individual MA entrants,  
13 how do you handle the transition for the 32 million members  
14 currently who would still be 90-plus percent of enrollment?  
15 If the 32 million are kept whole in their existing plans,  
16 then we have just increased the admin burden -- we've just  
17 increased the administrative burden, and again, big plans  
18 win.

19           And finally, conventional plans. While he's open  
20 to the notion of limited and thoughtful standardization, he  
21 agrees with page 14 that any potential standardization be  
22 only applied to conventional plans.



1           So next, I have Stacie.

2           DR. DUSETZINA: This is excellent work, Eric.

3           I am really struggling with this because I, in  
4 principle, really agree with the idea of standardizing the  
5 benefits, because I think having 41 plan choices is just --  
6 that's not reasonable. I have a hard time picking between  
7 three choices every year, and I do some of this for a  
8 living. So I think that's a terrible idea. Even if we  
9 gave everyone the tools, like Brian mentioned, to like shop  
10 their way to their best plan, we know that people don't  
11 often use those. They pick dominant plans. We just have  
12 really -- we would basically be setting it up so that the  
13 people with the most resources got the best plans and  
14 everybody else got probably something not so great.

15           So, because of those things, I'm really pro  
16 standardization of benefits, but I'm not exactly sure how  
17 to do that efficiently.

18           I do think that having maybe something like a  
19 minimum standard for saying you have vision, dental,  
20 hearing, I think limiting to those supplemental benefits  
21 would be a good choice, and maybe thinking about it more  
22 from the aspect of you can't say you have those unless they

1 meet this particular threshold of coverage, a little bit  
2 like the standard benefit for Part D where everybody has to  
3 meet this particular benefit, but there can be a lot of  
4 variability in like how specific medications are covered  
5 that best meet an individual person's needs. That might be  
6 able to help preserve some of the abilities of plans to  
7 innovate or meet individual beneficiaries' needs better.

8           But this is definitely a hard problem to solve  
9 because some choices are good, but I think we are at a  
10 place where there are way too many choices.

11           And I think my gut reaction to your question  
12 about if we pursue this, what types of plans should we go  
13 after, I think conventional plans makes sense to me, at  
14 least from a starting point. It's a lot of beneficiaries.  
15 I think they probably are pretty different than things like  
16 employer-sponsored plans or supplemental plans.

17           So that would be my gut reaction of at least for  
18 first steps.

19           MS. KELLEY: Brian, did you want to get in here?

20           DR. MILLER: I did have a very brief on-point  
21 response before we, I know, eventually have a long list of  
22 Round 2 questions. It's in response to Jonathan's,

1 Jaewon's, and Kenny's comments.

2 I think Jaewon mentioned the filter tool as a  
3 filter for complex choices. I realize health insurance  
4 purchasing, it's not easy, but like we don't have a good  
5 filter tool right now. And then I think that we need to be  
6 really worried of over-regulation and standardization, one,  
7 if we haven't done that filter tool correctly, but  
8 importantly, in the ACA exchange marketplace, there's a lot  
9 of regulation, a lot of standardization, which gives plans  
10 limited flexibilities to find ways to reduce costs. So if  
11 we standardize, we could actually end up, you know, driving  
12 up Medicare program costs, which would be bad.

13 MS. KELLEY: Amol.

14 DR. NAVATHE: Thanks, Eric, for a great work, and  
15 thanks for not only laying out a bunch of the various  
16 complex dimensions here but also synthesizing some of the  
17 feedback from the prior work. I think it's always helpful  
18 to see that organized and then communicated back to us as  
19 we think about this going forward.

20 So I have really four comments. I think, first,  
21 I think one governing principle here -- and I would hazard  
22 a guess to say that I think probably most or maybe even all

1 Commissioners agree about this -- is I think there's a  
2 principle here that we want to actually support  
3 competition, that the idea of potentially using  
4 standardization, the idea of potentially realizing that  
5 that may reduce purely the number of options is still  
6 fundamentally about trying to help competition and to focus  
7 competition in ways that are most meaningful to  
8 beneficiaries, to help beneficiaries essentially create a  
9 more competitive marketplace for the plans. So I think  
10 that's one really important governing principle that I  
11 think we're all on consensus about, but it may be worth  
12 articulating that very explicitly so that it's very clear  
13 what our intent is.

14           The second piece is I think standardization  
15 potentially is an important foundational element to trying  
16 to support that competition but also to the extent that we  
17 want to take on broader elements of Medicare Advantage  
18 strategy versus fee-for-service, the way that MA is  
19 priced. We had previously done work around bidding and  
20 other things, that standardization can be a foundational  
21 element to potentially enable those other types of reforms  
22 that we're seeking to try to make the overall Medicare

1 program, including Medicare Advantage, more efficient. I  
2 think that's another key element to point out.

3           A third point is that I think there are many ways  
4 potentially to interpret the data. So you take figure 5,  
5 for example, from the mailing materials, which I think  
6 Cheryl also brought up in her comments. We had the box  
7 plots of high participation plans. I think we can, in  
8 part, point out the variation. Some of that variation  
9 probably is unwarranted in the sense that beneficiaries may  
10 not have been seeking that variation. There's probably  
11 also a component of that variation that is some sort of  
12 preference heterogeneity variation and preferences of  
13 beneficiaries as well, and I think this highlights the  
14 point that, again, you have highlighted, Eric, but I think  
15 other Commissioners have as well, which is we want to  
16 retain this flexibility to match preferences or values of  
17 beneficiaries but also to then support that innovation from  
18 the plan side. So I think it's important that we use  
19 multiple lenses to sort of interpret the data that we have  
20 in front of us.

21           The one point I wanted to make about the non-  
22 standardized plans and/or benefits to think about here is

1 that the way this market works is when we think about  
2 standardization, we're thinking about standardizing  
3 multiple versions of standardized benefits for Part A, Part  
4 B, and then potentially for vision, dental, hearing is what  
5 we put out on the table, at least in a sense, that the  
6 question -- you raised the question of what about non-  
7 standardized benefits or non-standardized plans.

8           And I think it's important to differentiate the  
9 two. I think Jonathan highlighted that he would say, for  
10 example, standardized benefits -- standardized plans around  
11 these specific benefits but then allow flexibility beyond  
12 that for these maybe non-standardized supplemental benefits  
13 is one way to view the world, and I think that makes sense.  
14 That is wholly different from having non-standardized plans  
15 that don't have to abide -- or that don't abide by the  
16 standardization scheme or schema that we might put forth.

17           And the reason I'm drawing this distinction, I  
18 think it's fundamentally important because plans are still  
19 able to price. Even if they have a standardized benefit  
20 structure, they are still going to be able to price the  
21 plan the way they want, and so you could end up -- if you  
22 have many, many non-standardized plans alongside

1 standardized plans, you could end up in a world where the  
2 standardized plans are basically priced in a very  
3 unattractive way. And despite having standardization, we  
4 effectively have a non-standardized marketplace.

5           So I think, to some extent, just to put it out  
6 there, I think if we're effectively trying to induce some  
7 standardization to help promote competition amongst these  
8 that we need to also contemplate constraining the number of  
9 non-standardized options. Otherwise, we could try to do  
10 something and actually not accomplish it at all, and I  
11 think that would be obviously not what anybody is seeking  
12 here.

13           So those are the four key points I wanted to  
14 make. Coming back just in my reflection, I would say I  
15 support the work, generally speaking. I think the way that  
16 Jonathan kind of highlighted that there could be multiple  
17 standardized options within Part A, Part B benefits, that a  
18 subset of supplemental like vision, mental, hearing but  
19 then leading the non-standardized benefits to be innovated  
20 and allow plans some flexibility there, I think it's  
21 probably, roughly speaking, where I'm landing in terms of  
22 what makes sense. And I think the idea of having

1 illustrative plan options in a future presentation sounds  
2 like it would be a great next step.

3 Thank you.

4 MS. KELLEY: Brian.

5 DR. MILLER: So this is a really interesting  
6 discussion. It's the 21 flavors of MA or 41 flavors of MA.  
7 So poor Eric got saddled with this challenging problem of  
8 how we solve this.

9 Just taking a step back, when you think about the  
10 41 flavors of MA at the county level, comments for all of  
11 us, how do you solve that for like a consumer? Right?  
12 Because the beneficiary is a consumer or their proxy.  
13 Standardization is one option.

14 Another option, which is saying is change the  
15 filter through which the beneficiary is looking for their  
16 choice options.

17 A third option is change the way in which those  
18 41 options are communicated to the beneficiary. For  
19 example, C-SNPs, say, as a neglected marketplace -- I'm one  
20 of the few people that's interested in, I admit -- is one  
21 where you could have disease-specific marketing for, say, a  
22 plan with targeted beneficiaries with heart failure with



1 reduced DF and a customized network for them.

2           So when we talk about -- I don't view this  
3 chapter as a standardization chapter. I view this as how  
4 do we manage complex choices.

5           Reasons why I'm very concerned about  
6 standardization in addition to my other comments about  
7 rising costs, standardization produces -- or prioritizes  
8 centralization over dynamic markets in emergent order.  
9 What do I mean by that? Specifying a lot of stuff in  
10 statute for the Medicare program has not gone very well.  
11 If we look at the three-day post-acute care rule, which was  
12 established -- I looked it up -- in 1967, before when many  
13 of us were born, the average length of hospital stay was  
14 13.7 days. Observation status didn't exist as a payment  
15 category. Now, that causes all kinds of problems for  
16 something like 20- or 30,000 beneficiaries who get  
17 discharged from observation care and need to go to a SNF  
18 and can't.

19           We haven't really done the transparency before  
20 standardization. So one of the big complaints that benes  
21 have about MA is like, "Who is my doctor in the network? I  
22 don't know if my doctor is in the network." There's a lot

1 of literature that says that provider networks are not up  
2 to date. We can all pull the Health Affairs papers on  
3 that. They're very well done, and they're accurate. The  
4 provider network directories are not up to date. In the  
5 Plan Finder, you can't mix and match benefits. You can't  
6 pick an MA plan, put in your doctors, put in your drugs,  
7 and then say what's my fee-for-service comparison plus med  
8 sup plus my PDP and see what your monthly cost is.

9           And actually, there's a nice paper by Lisa  
10 Grabert in Inquiry just about this, about -- from last year  
11 saying Medicare must provide additional cost and access  
12 information to enhance decision-making around tradeoffs  
13 between Medicare Advantage and Medigap. So I think we need  
14 to solve that information problem first, and that a  
15 discussion of standardization is premature.

16           And then I would say that the preservation of  
17 benefits innovation is a real thing. It's not like an  
18 office-space joke with people hiding in the cubicles. And,  
19 you know, I went back a little further in history, and I  
20 found a 1987 -- so the year after I was born, I admit -- a  
21 paper from Health Care Financing talking about TEFRA risk  
22 plans. And that was when I first got into health policy.

1 I had to look up what TEFRA was, right?

2 So they found that 84.7 percent of TEFRA-risk HMO  
3 enrollees had a prescription drug benefit. So Medicare  
4 benes and fee-for-service didn't get this until 2003, when  
5 I was in college. So benefits innovation is a real thing.  
6 So we really need to be careful about standardizing it,  
7 because if we crush that, do we really want elderly  
8 Americans to wait 20 years for what could be a new benefit  
9 that we don't know exists?

10 MS. KELLEY: Betty.

11 DR. RAMBUR: Thank you. I appreciate this work  
12 and the interesting conversation.

13 So, Michael, you open by saying, is it the  
14 number? Is it the transparency? To me, the dizzying array  
15 is a part of the challenge with transparency, and that so  
16 much choice is no choice at all. And that goes back to the  
17 competition piece. If you don't know what you're buying,  
18 it's hard to have real competition, and that drives down  
19 costs and improves quality.

20 Certainly, there can be better filters. I agree  
21 with that, but I think no amount of information will take  
22 away the asymmetry of information and the constant

1 marketing that I see on television.

2           So where I'm at for now -- and I'm certainly --  
3 you know, I will evolve as we study this more -- starting  
4 with conventional plans, I tend to agree with sort of the  
5 metal-level-type idea so that there can be innovation  
6 within that space.

7           I do support some level of non-standardized  
8 benefits that are above the basic -- as a place of  
9 innovation and a place to test some of these benefits that  
10 then may become standard, and it seems to me if we wanted  
11 to minimize the kerfuffle, there would be grandfathered  
12 plans that would sunset at a certain period of time, you  
13 know, even though this is a market that has a fair amount  
14 of kerfuffle, anyway.

15           I think one of the most important things to me is  
16 that there's very clear information on what people are  
17 paying in terms of premiums and then out-of-pocket max and  
18 cost sharing.

19           And also, in your report, you said dental,  
20 hearing, and vision are covered to some extent, and I'm  
21 sure this has happened to all of you. So many people think  
22 they have dental, hearing, and vision, and they actually

1 have, in some cases, a very small defined benefit package.  
2 So being clear on what you're giving up in the networks is  
3 a different issue but really important.

4           So I'm very enthusiastic about this work, and I  
5 look forward to studying it more with all of you. Thank  
6 you.

7           MS. KELLEY: Cheryl.

8           DR. DAMBERG: Thank you, and thank you, Eric, for  
9 such a great chapter.

10           I'm very supportive of this work, but I fully  
11 appreciate -- and I appreciate all the comments from the  
12 Commissioners about the complexity of trying to make  
13 progress in the space.

14           I do think that we need to help the consumer.  
15 The number of choices is overwhelming, and we know they're  
16 making suboptimal choices. And, you know, I think we can  
17 look at this through one lens, which says choices provide  
18 options to best meet beneficiary needs, and maybe it's all  
19 about what Brian is describing as an information problem,  
20 and we're not helping people make the right matches. But I  
21 think there's a big assumption on the table about people  
22 making the right choices, and I think the evidence to date

1 is that they're not.

2           And I worry a bit about sort of this tension  
3 between, you know, the innovation. So I'm not in favor of  
4 tamping down on innovation, but I also think a lot of  
5 what's going on in the marketplace is market segmentation.  
6 And so I'm not convinced that sort of all these choices are  
7 really leading to innovative products that consumers are  
8 accessing and knowingly accessing.

9           So I do favor continuing down this path, whether  
10 we solve this problem this cycle or next, per Kenny's  
11 comment. I think there's still a tremendous amount of work  
12 to be done to understand sort of the implications of the  
13 different choices.

14           I would start with the conventional plans as the  
15 focus. I am in favor of limiting the number of plan  
16 options that any given sponsor can offer. I do think the  
17 differentiation of, say, HMO and PPO is important,  
18 particularly because they usually mean different provider  
19 networks as well as generosity. And I kind of like the  
20 idea of sort of creating some minimum threshold for some of  
21 the supplemental benefits.

22           MS. KELLEY: Gina.

1 MS. UPCHURCH: Thank you.

2 One of my favorite quotes was from a participant,  
3 and I should say I run a program and with the SHIIP  
4 coordinating site, Senior's Health Insurance Information  
5 Program site for Durham, North Carolina. But he said to  
6 me, "Don't get me wrong. I like choice, but I wanted to  
7 choose between paper and plastic, not all this mess." And  
8 I asked him, could I use that quote?

9 So what we do, as SHIIP sites, is choice  
10 architecture, try to help people. Now, if people have a  
11 crystal ball what the next year is going to bring -- but we  
12 do our best to try to help people understand what their  
13 options are.

14 But building on Betty's comment -- because the  
15 plethora of options -- it makes transparency difficult, and  
16 it makes less meaningful choice because there are too many  
17 variables moving at the same time. So I am definitely for  
18 standardization.

19 There needs to be meaningful differences that's  
20 pointed out in these plans. Otherwise it leads to  
21 decision-making paralysis and what wins, getting at Kenny's  
22 comment, about administrative burden for having to put more

1 information in the Plan Finder or something like that.

2           What happens now -- and then the big players  
3 would win -- that's happening now because it's marketing.  
4 Getting to the comment, it's just marketing that's driving  
5 that. It's not because the Plan Finder is not showing the  
6 -- the Plan Finder needs more standardized information, but  
7 even with that, marketing is certainly driving what's  
8 happening.

9           I do think we should start with conventional  
10 plans, but I will say a lot of people with employer-  
11 sponsored plans come to SHIIP sites because they want to  
12 know if they should leave their employer-sponsored plans.  
13 And I don't know what the Inflation Reduction Act is going  
14 to do or the Part D redesign, how that's going to deal with  
15 retiree drug subsidies and what that means for employers  
16 and what they're going to do about the retiree benefits  
17 moving forward. But we always get calls from companies and  
18 people that are retiring from companies going, "I could  
19 stay here" -- even federal employees come to us. "Should  
20 we go to the one of these things we see on TV all the  
21 time?" So we do have to sort of understand how to compare  
22 these employer plans with these conventional plans. So it



1 would be helpful to have some standardization, but I agree  
2 that conventional plans first.

3           SNPs, especially D-SNPs, dual special needs  
4 plans, we have this problem with lookalike D-SNPs where  
5 they're not fully integrated. So I at least think that  
6 needs to be crystal-clear this is a fully integrated plan.  
7 This is not a fully -- I mean, that standardization needs  
8 to be there for everybody to see.

9           I don't think there should be not non-  
10 standardized plans. I mean, I agree that's the point.  
11 You're trying to standard. That doesn't mean you can't do  
12 things that are innovative. They just, you know, need to  
13 be part of the scoring for standardization.

14           Right now, even if you go on the Plan Finder -- I  
15 actually went on it this morning to look at the Plan Finder  
16 because they're making some changes, and you could see the  
17 "extras." Thank you for calling them that. And they'll  
18 say often when you look at dental or vision, it will say  
19 "plan limits apply," you know, advanced plan approval  
20 required. It won't tell you the details, but it's set up  
21 so that it could fairly easily tell you the detail already.

22           Almost done. One of the things, it would be a

1 rough transition for people that are in plans. I don't  
2 know that I love grandmothering, grandfathering plans in,  
3 though. Right now, what happens is people get -- they're  
4 in one plan that goes away from that company. But if it's  
5 similar to another plan that company offers, they just roll  
6 you over into that plan. I'm just wondering if that's  
7 possible with some of these standardized plans to put  
8 people in similar plans.

9           Even if we created perfect tools and lovely  
10 standardization, we have to remember who we're trying to  
11 help. We are talking -- what? -- 10 percent for some of  
12 the people get help sort of sorting through all of this.  
13 So it's marketing and how -- and I appreciate CMS's -- you  
14 know, what they've done recently to help guide some of this  
15 and what is and is not allowed so we can have a perfect  
16 tool. But what I really think we need to focus on is how  
17 well these plans are taking care of the people they're  
18 supposed to take care of, so just that drive again towards  
19 the outcomes for people that enroll in these plans.

20           And lastly, while I can, this chapter -- I've  
21 just talked to some agents and brokers recently about how  
22 they get paid, and it's very interesting, so just sort of

1 understanding how they are incentivized to enroll people in  
2 Medicare Advantage plans and how that works and so we  
3 understand that, because I think that's critical, because a  
4 lot of people depend on them.

5 Thank you

6 MS. KELLEY: Scott.

7 DR. SARRAN: Yeah. Just a couple of comments or  
8 really opinions, and great work, Eric, in crystallizing and  
9 putting this squarely on the table.

10 Basically, having thought about this and  
11 listening to all the great comments, here's where I land on  
12 this. I think we should recommend an approach towards  
13 standardization for general MA, specifically excluding SNPs  
14 and employer-sponsored. That would be my recommendation.

15 I think we should recommend transitioning away  
16 from non-standardized plans with a finite time period,  
17 whether that's two years or whatever, and I think there  
18 should be a finite number of standardized plans that each  
19 insured should offer. That's where I'd land.

20 I do think we want to highlight, as, Brian, you  
21 point out, that it's 2023. There should be better front-  
22 end tools to help people make choices, sort of what's

1 important to you on a one-to-ten scale. Is it my doctor?  
2 Is it my drug cost? Is it my -- no hassle with prior --  
3 you know, there's a finite number of things, and people  
4 could weigh all those and then rank some plans, and it just  
5 feels like that's not that difficult an expectation to  
6 execute on in 2024 or whatever. So I think we should  
7 highlight that there should be better front end -- maybe  
8 "sophistication" is the right word.

9           And, Brian, your point, I think we want  
10 innovation, but I think it's going to be around innovation  
11 around transparent performance on other benefit options  
12 besides the cost sharing on A or besides what you can  
13 pretty -- lump into a metallic kind of tier for dental,  
14 vision, and hearing. I mean, that's not innovation.  
15 That's just high, low, kind of, sort of stuff. We want  
16 innovation. It's can you deliver a hassle-free experience  
17 and deliver a concierge experience? Are people really  
18 happy with you? Do you offer respite services? I mean,  
19 there's just a whole bunch of, you know, really innovative  
20 things, and many of those exist primarily and will exist  
21 primarily in SNPs. But it's easy to see how some of those  
22 could become mainstream, and those should be the points

1 that we want to -- we want MA plans to innovate around, not  
2 how they construct a dental benefit.

3 MS. KELLEY: Robert.

4 DR. CHERRY: Thank you.

5 Eric, I think you did a really nice job of teeing  
6 up the discussion. The questions were right on point.

7 Superficially, it seems like a really easy  
8 problem statement, right? We offer an average of 41  
9 different plans. Let's streamline it and make the choices  
10 easier, but obviously, it's more complex than that.

11 One area that seems to be low-hanging fruit --  
12 and several others have mentioned it before -- is that for  
13 those plans that offer dental, vision, and hearing,  
14 standardizing those supplemental benefits seems to be, I  
15 think, low-hanging fruit because it will reduce the number  
16 of choices right there. Now, it might reduce the number of  
17 choices from 41 to 39, but at least it reduces the number  
18 of choices.

19 I tend to agree with Scott that it would be  
20 easier to choose or narrow down the choices of 39, let's  
21 say, with online tools. So if I have a primary care  
22 doctor, a cardiologist, and a dentist and this is my local

1 hospital and I punch in all the names -- because probably  
2 for most people, they want to make sure that the physicians  
3 that they're working with and the hospital that they're  
4 most closest to are in network. So if you punch that in  
5 and it comes out with six different options, that makes it  
6 a lot easier. So I think the online tools could be key,  
7 and it's not necessarily the number of different plans.  
8 But we're asking individuals to make -- you know, to go  
9 through a manual process of narrowing it down.

10 I think that the larger question is, should there  
11 be a balance between standardization and flexibility and  
12 benefit design? My personal feeling is yes. In the  
13 interest of innovation, there should be some flexibility.  
14 The question is, should that flexibility be open ended, or  
15 should it drive certain types of goals? And I would say  
16 for non-standard supplemental benefits, not including  
17 dental and vision and hearing, those supplemental benefits  
18 should really drive goals that close the gaps around health  
19 care disparity and social determinants of care.

20 So it was mentioned in your report too. Some  
21 plans actually offer meals. Some offer for food and  
22 produce. Some offer non-medical transportation, because

1 they've assessed their community needs and determined that  
2 that's really important. There might even be disease-  
3 specific conditions that fall into that category as well,  
4 where there might be selected congestive heart failure  
5 patients that really need a scale at home for weight  
6 measurements. Maybe they need a home blood pressure  
7 monitor as well, and those things can be provided by the  
8 plan as well. And that's the kind of innovation that I  
9 think we want to see and also, you know, closes some of the  
10 disparities that exist out there.

11           So I think that the bottom line is I would  
12 encourage some degree of decentralized innovation, provided  
13 that it's targeted and based on community needs and closes  
14 health care disparities, and then supplement that with  
15 online tools to help the beneficiary narrow down the  
16 choices.

17           MS. KELLEY: Okay. I have a comment from Greg,  
18 and he says great and informative work. He  
19 enthusiastically supports the document and the general  
20 direction.

21           In the interest of clarity, he believes that a  
22 consistent benefit for Part A and B should be defined or

1 ideally two or three levels of benefits be defined, as  
2 shown on slide 10, with which plans should align.

3 He initially wrote this along the gold-silver-  
4 bronze concept but realized that many might interpret that  
5 as expecting consistent actuarial value, which still  
6 provides the potential for enormous variability. Instead,  
7 he believes we should have consistency of actual benefits  
8 within levels.

9 He would also support benefit consistency for the  
10 three main extra benefits, using the term as Gina  
11 suggested, vision, hearing, and dental.

12 All that said, he believes that additional extra  
13 benefits, such as transportation, nutrition, many other  
14 things, should allow significant flexibility, thus,  
15 encouraging innovation that can lead to enhanced care,  
16 consumer attractiveness, or both.

17 To Mike's opening point regarding the number of  
18 plans, Greg is less concerned by the number of plans than  
19 the complexity of understanding what the plan is actually  
20 offering. With this in mind, he thinks the ideal would be  
21 if each plan could be accurately characterized on a  
22 spreadsheet with no more than eight columns, which would



1 allow consumers to visualize tradeoffs. And he would be  
2 happy to expand on this concept offline.

3           Finally, while this is outside of the current  
4 recommendation, he would offer a placeholder for further  
5 discussion. The star rating would ideally become a  
6 reflection of people's overall experience with the plan.  
7 So the intangibles, such as panel adequacy, prior  
8 authorization, and payment hassles, et cetera, would be  
9 identified in the star rating if they negatively impacted  
10 the beneficiary experience.

11           That was from Greg. I also have a comment from  
12 Larry. He says: One key question, to what extent do  
13 insurers offer lots of plans because they believe that each  
14 one can be desirable and beneficial for a specific set of  
15 beneficiaries, and to what extent because they believe it  
16 will make it possible for them to segment the market in  
17 ways that are favorable to the plan but likely not good for  
18 beneficiaries?

19           On a very general level, Larry thinks that the  
20 benefits of more standardization greatly outweigh the  
21 benefits of more innovation from having more plan designs.  
22 He thinks the Medigap example is a good one. He's just

1 gone through the Medigap choice process himself, and even  
2 there, it was not easy.

3 He agrees with not trying to standardize benefits  
4 outside of A, B, dental, vision, and hearing.

5 He agrees with standardizing for conventional  
6 plans and would not permit offering of non-standardized  
7 plans while allowing non-standardization for other than A,  
8 B, and C.

9 He does think that plans should be able to offer  
10 two or three different types of provider networks: HMO,  
11 PPO, POS. Though if they also offer, say, three different  
12 benefit packages per type of provider network, that makes  
13 the number of plans quite large. What can be done about  
14 this? He hopes that we can devote a substantial portion of  
15 the discussion to this issue, which seems to him to be  
16 quite a big deal. Since the number of plans grows rapidly  
17 as parameters vary, it might make sense to limit the number  
18 of plans per insurer. Even at two plans per insurer, this  
19 would be 16 plans in an average market. But let the plans  
20 pick the two plans they want to offer that they think they  
21 can best offer.

22 Finally, he's concerned about Kenny's concerns

1 that certain requirements could drive smaller plans out of  
2 markets and would like to hear more discussion on this.

3 And next, I have Tamara.

4 DR. KONETZKA: Thanks.

5 Mostly, I'm agreeing with a lot of things that  
6 have been said, but I wanted to clarify a few things.

7 I agree completely with what Larry said about the  
8 benefits of -- and I think there's a lot of agreement about  
9 this. The benefits of standardization greatly outweigh a  
10 lot of the disadvantages we're talking about in terms of  
11 reducing innovation.

12 I actually think that combining, you know, sort  
13 of packaging some of the vision, dental, hearing would be  
14 fine. I mean, I'm not sure it's so necessary to have two  
15 different plans with different generosity on vision and  
16 hearing, for example. I think we could group these without  
17 losing a lot, group these into a small number of  
18 categories.

19 The thing that I think it's really important to  
20 have is to allow different types of plans, the HMO/PPO for  
21 each sort of generosity basket. So I think that's a really  
22 important choice variable for consumers, and so, you know,

1 one thing we might imagine is a choice interface where, you  
2 know, one of the buckets of Part A, Part B, and vision,  
3 dental, hearing could be chosen, and then what plans  
4 differentiate themselves on then are the premium, the extra  
5 benefits that they offer, the quality, and whether it's a  
6 PPO or HMO. And so that if you choose one of your buckets  
7 that you think is most appealing in terms of those original  
8 benefits, then you can compare plans on those other four  
9 areas, and that seems to me sort of manageable if we get  
10 the number of original buckets down.

11 And then I agree with what many people have said,  
12 that I don't think that we lose a lot in innovation by not  
13 allowing non-standardized plans. So I'd be in favor of not  
14 allowing them.

15 DR. CHERNEW: I'm going to go, and then Jonathan  
16 is going to kick off the mythical Round 3. And then we can  
17 have a little bit more back-and-forth about where we are,  
18 but it's useful at least for me to summarize at this stage.

19 So a few things. My general belief is that while  
20 innovation is important, a lot of times, these things that  
21 are claimed to be innovative are just ways to avoid people  
22 competing, and so they intentionally make the -- if you

1 look at health insurance, home insurance policies and  
2 stuff, like there's ways that it's standardized, but a lot  
3 of what's going on is to make the policies very hard for  
4 consumers to compare under the guise of innovation. I do  
5 think there is actual real innovation, but I think a lot of  
6 what's going on is -- that I have a colleague that has a  
7 paper that says one of the things that's going on is you  
8 offer a benefit, you get a lot of people in, then there's a  
9 lot of inertia, so you raise the premium, and then you get  
10 the new people in with a very similar plan but slightly  
11 lower premium. And you do this sort of attract-and-harvest  
12 strategy. So I think there's a lot of deleterious things  
13 that go into this related to that.

14           And I think if you were to look, we did this on  
15 the exchange, and what the plans were offering was called  
16 "innovative." It was like 50 cents more on a primary care  
17 visit, you know, these really minimal things that no one  
18 would claim are innovative in the grand scheme of things.

19           I do think there are innovative things to do, by  
20 the way, but I am very strongly in the view that a lot of  
21 what we're seeing is actually differentiation that would be  
22 hard to characterize as innovative if I actually showed you

1 the plan benefit structures and said, boy, is this one  
2 really that innovative? Not to mention, it can be used to  
3 segment populations when we have a risk adjustment system  
4 that we think is problematic and a bunch of other things.

5           So I want to double -- we obviously meet on  
6 Wednesdays, leadership before -- and I want to double down  
7 on Amol's point, which I made and we made yesterday, which  
8 is we want to have -- we want to promote competition.  
9 Standardization can help that. What you need is you need  
10 to have multiple carriers competing on the same thing. If  
11 you have five carriers, one offers Plan A type, one offers  
12 Plan B type, and they all charge the monopoly price of  
13 those different types, there's not a lot of competition.  
14 So we want density of plan offerings, and at least for me,  
15 it doesn't bother me if there's eight plans offering a  
16 standardized set of things, because then you can figure out  
17 what the prices -- and most of the time, you'll find the  
18 prices are similar. Most of the time, people choose one,  
19 and it doesn't make that much of a difference. The  
20 literature on people making bad plan choices, which Eric  
21 alluded to in Part D and in Part A and B and actually life,  
22 in general -- and I would say myself included -- is really

1 enormous.

2           So what I'd like to hear a little bit around --  
3 and maybe Jonathan is going to say something about this --  
4 is I think what I'm hearing is there's pretty clear support  
5 for the idea of standardizing with multiple levels, not  
6 just one, but multiple levels of A, B, vision, dental, and  
7 hearing. And for those that think, well, there's going to  
8 be a tiny innovation in details of how we do that, I'd like  
9 to hear what that innovation is, because that's not, oh,  
10 we're going to add Part D or we're going to add respite.  
11 You know, those are sort of -- I'd like to know what the  
12 innovation is they think we're losing, because I think  
13 there's a lot of value to that type of standardization.  
14 Again, people might not agree with that.

15           Where I am more on the fence is the extent to  
16 which -- so one approach is we basically work to get  
17 consensus. We might not have consensus on that, but we  
18 work along that path, and then if you're going to go  
19 another step -- and the more steps, the more uncertain I  
20 become -- towards, for example, getting to a point where  
21 you say any carrier can only offer three plans or five  
22 plans, I worry about that because then you might not have

1 enough competition within a similar standardized plan, and  
2 that's kind of problematic. Or if we got to a point where  
3 we said we need to combine -- there's 30 permutations of  
4 standardized A, B, and D plans combined. I agree 100  
5 percent with what Tamara said about we have to have one for  
6 PPOs and HMOs. You can't, you know -- so we have to allow  
7 some variation along those things. You still get a ton of  
8 plans, and I worry about saying something like do whatever  
9 you want, but there's only three, or we're going to pick  
10 our version of how those should -- you know, you cannot  
11 have generous dental and stingy vision. I get worried when  
12 we -- I'm not saying we can't, but when we start to pick  
13 our own version to get to four standard plans out of a set  
14 of permutations of standardized benefits that could be much  
15 bigger, I get a little uncomfortable. I'm not -- get a  
16 little uncomfortable. I'm going to stick there.

17           So, Jonathan, you should lead off Round 3, but  
18 what I'm looking for is to figure out two things. How  
19 close are we to support or not of a -- what I would call  
20 "weak standardization," which is if you're going to offer  
21 dental, this is what you're going to offer or these are the  
22 three versions of dental you're going to offer. You're not



1 going to offer your own version of how many cleanings you  
2 get and compared to your crown copays. The innovation is  
3 not low cleaning and high crown copay, to some  
4 standardization. So I'd like to see if we could  
5 standardize within those big areas.

6           If we have consensus or seem to be able to get  
7 there, how much further should we worry about limiting the  
8 set of permutations amongst these things that can be quite  
9 big or limiting the total number of plans that a carrier  
10 offers?

11           I'm sorry. That was longer than I meant it to  
12 be. That's always the way. That's why Jim used to tape  
13 me. Go on, Jon.

14           DR. JAFFERY: No. It's okay.

15           So my comment was not really to address those  
16 things, but I will start off by saying I do think that your  
17 last point, Mike, about -- I think the more important thing  
18 is to get to these are the -- if you're going to offer  
19 dental, these are the types of dental, and it can't be 600  
20 different permutations of, well, you get two and a half  
21 cleanings a month and you get four.

22           But my comment was actually going to be -- so I

1 wanted to go back to the tools thing they were talking  
2 about because I would agree that it would be great to have  
3 additional tools up front to help beneficiaries make  
4 decisions, but I think also we should be very -- you know,  
5 keep our eyes wide open about the limitations that those  
6 tools could offer and even the ones we have now.

7           When I go to book a flight, often I'm looking at  
8 a couple things, right? I, of course, care about price,  
9 like everybody else, and I also want to know, if I'm trying  
10 to get somewhere, how early I can get there, the arrival  
11 time, and I want to know duration, because I don't want to  
12 have a four-hour layover somewhere. And so you can't  
13 choose all those things, even in these tools, right? So  
14 those tools are fine if you could make lots of multiple  
15 choices, if you're trying to make binary decisions, you  
16 know, is my primary care doc in or out, is my cardiologist  
17 in or out, do I want to fly through Detroit or not, but  
18 once you start to get to things that aren't binary, you  
19 can't do that.

20           And so my concern is that what we're talking  
21 about for beneficiaries is such a large number of  
22 variables, some of which are binary and many of which

1 aren't, that it's not going to be useful, particularly then  
2 if you get into a situation where you've got the dental  
3 things where -- I can't remember. Some offer 12 cleanings  
4 a year or something like that. I don't know. I don't know  
5 who gets their teeth cleaned that much and why that's an  
6 attractive benefit.

7 [Laughter.]

8 DR. JAFFERY: But I just think we need to be  
9 careful about what those tools can and cannot do.

10 DR. CHERNEW: Okay. We're coming towards the  
11 end. We do have five more minutes, and I would like to get  
12 a sense. In fact, Brian, I may call you out since you seem  
13 to be -- I apologize for calling you out, but you seem to  
14 be more skeptical of any version of standardization.

15 DR. MILLER: Recognizing that we are advisors to  
16 Congress and not CMS, I think standardization in statute is  
17 a bad idea. It tends not to age well over time, and many  
18 problems that I run into in Medicare program policy that  
19 beneficiaries, doctors, industry, Congress, CMS even,  
20 volunteers and end up in my inbox are frequently ones that  
21 result from a statute that over-specifies things, be it  
22 number of days of hospital stay required for post-acute

1 care, be it number of plans.

2 If you did want to do standardization, which I do  
3 not support, I think that standardization should be done  
4 through rulemaking, not through Congress.

5 I think we should also look at the Federal Health  
6 Employee Benefits Program as a model, if you wish to do  
7 that.

8 There's a -- Heritage Foundation has published a  
9 lot of papers on this, including one that I pulled from  
10 2003. The FEHB is a model for Medicare reform. In the  
11 FEHB, OPM negotiates, works directly with plans, as opposed  
12 to it being in statute or even rulemaking. I think putting  
13 this in statute is a really bad idea. I think putting it  
14 in rulemaking is less of a bad idea. But I definitely  
15 would not support putting it in statute.

16 DR. CHERNEW: So just to be clear, the  
17 recommendation we would have would not be Congress should  
18 define the benefit packages, and I think the way the  
19 Medigap plans work, it's not when they go from however many  
20 to however many that Congress and statute change them. I  
21 do think it's a CMS with -- that Paul tells me, NAIC  
22 process to know what the details are.

1           Although we are advisory to Congress, we do make  
2 a number of recommendations to the Secretary about what  
3 should happen when we were talking about alternative  
4 payment models as across the board.

5           So I think that the issue -- as I said at the  
6 very beginning, our recommendation is not going to be  
7 granular, although we may have a policy option, as Eric  
8 laid out. We are not going to have a recommendation that's  
9 going to say there should be three Part A, Part B plans,  
10 two levels of generosity for vision, dental, hearing, and  
11 they should not include 12 cleanings because apparently  
12 that's bad. But whatever it is, we aren't going to --  
13 we're going to have something that's going to be -- if  
14 there's a recommendation, it's going to be more generic,  
15 and we can think about the wording and who the  
16 recommendation is to. But it need not be -- in fact, I can  
17 guarantee you it will not be a version of Congress should  
18 specify in statute what the Medicare Advantage benefit  
19 packages should look like.

20           DR. MILLER: May I respond?

21           DR. CHERNEW: You may.

22           DR. MILLER: Yeah. So I would not -- yeah, we

1 definitely shouldn't be telling -- we do not want Members  
2 of Congress being tasked with specifying whether there are  
3 12 cleanings or 2 dental cleanings per year. And I would  
4 suspect that they would not want that either.

5           If we were suggesting that CMS do it for  
6 rulemaking, I'd be open to that for A and B, less so for  
7 the supplemental benefits, because I think that that market  
8 still has not become clear. There's not a clear trend of  
9 what the -- there's no -- just like the FEHB, there's the  
10 dental, vision, and hearing versions. I don't think that  
11 that is particularly clear right now for MA.

12           DR. CHERNEW: Gina, you're going to get the last  
13 word before I actually get the last word.

14           MS. UPCHURCH: Good. This is just a minor  
15 comment, but I do believe that in trying to help consumers,  
16 you certainly have brokers, you have agents, you have  
17 family members, but even just SHIIP programs -- and I don't  
18 know if we could pull this together, but I do know that  
19 some SHIIP volunteers and stuff have left because they're  
20 overwhelmed by all of this. And I do think that's bad for  
21 consumers that are trying to get help, but you have people  
22 that are trying to help them. There's so many moving

1 variables that it feels like you're just, picking something  
2 out of the air. So I would agree with standardization in  
3 the terms that you just defined, Michael, not specificity  
4 at this point but just in general for that reason also, not  
5 only for the consumer but for the people trying to help  
6 consumers.

7 Thanks.

8 DR. CHERNEW: So we will take all of this under  
9 advisement, and we will have a debrief about where we are.  
10 There's obviously a lot of issues that are going on in this  
11 space, and I think one thing that you all should think  
12 about -- I'll just say one of them for me -- is what  
13 unintended consequences there are. And one of the  
14 unintended consequences that I'm worried about is, if we  
15 push all the competition into these supplemental benefits,  
16 I'm not sure that the outcome ends up being necessarily  
17 better, because there's things that could happen in that  
18 world. It just makes it more complicated, and how we  
19 manage that is challenging, but I don't have a good sense  
20 of that.

21 So I really do appreciate the work that, Eric,  
22 you've done on this. When we started this last cycle, I

1 knew it was going to be a challenging topic, and you've  
2 really done a terrific job.

3           And thank you for all the comments that you all  
4 made. It was really helpful to both hear your general  
5 views about this and the experiences that you've had with  
6 organizations you've worked with.

7           So anyway, I am grateful for all of that, and we  
8 are going to now take a five-minute break. And we are  
9 going to come back and talk about coding of disease in  
10 Medicare Advantage. I think that is the next topic. I see  
11 Andy is just smiling. He's waited so anxiously. So we'll  
12 see you all again in a few minutes.

13           [Recess.]

14           DR. CHERNEW: Okay. Even by the standards of an  
15 analytic organization, which MedPAC is, some topics are  
16 particularly analytic, and we have the privilege of  
17 discussing one of those now which is both analytic and  
18 unbelievably important and something that we have been  
19 doing at MedPAC for literally decades, at least more than  
20 one.

21           Anyhow, in that context, I'm going to turn it  
22 over to Andy who is going to talk to us about coding in



1 Medicare Advantage plans. Andy.

2 DR. JOHNSON: Good afternoon. This presentation  
3 will discuss ways to improve MedPAC's estimate of MA coding  
4 intensity and will assess an alternative method, the  
5 Demographic Estimate of Coding Intensity, or DECI method.

6 The DECI method has produced estimates of MA  
7 coding intensity that are double MedPAC's estimates. We  
8 will present analyses reconciling the differences in the  
9 two sets of estimates.

10 The audience can download a PDF version of these  
11 slides in the handout section of the control panel on the  
12 right-hand side of your screen.

13 First, I'll present background information on MA  
14 payment policies, coding intensity, and MedPAC's cohort  
15 method of estimating coding intensity. Then we will  
16 discuss improvement to MedPAC's cohort method and present  
17 the results of implementing those revisions. Next, we turn  
18 to the DECI method, where I will present results from two  
19 sets of analyses.

20 First, we implemented the DECI method as intended  
21 by the original authors but with complete risk score data,  
22 which is unavailable to researchers.

1           Second, we revised the DECI method to incorporate  
2 two improvements.

3           Finally, we asked for Commissioner feedback about  
4 adopting the revised DECI method for estimating the impact  
5 of MA coding intensity in future MedPAC work.

6           Medicare pays MA plans a capitated payment for  
7 each enrollee that is the product of two factors, a base  
8 payment amount that is calculated for each plan and a  
9 beneficiary risk score which is an index of beneficiaries'  
10 expected spending relative to the average fee-for-service  
11 spending.

12           CMS uses risk scores from the CMS-HCC model to  
13 adjust MA payments. Risk scores increase payment for  
14 beneficiaries who are expected to be more costly than  
15 average and decrease payment for beneficiaries expected to  
16 be less costly than average. The CMS-HCC model uses  
17 demographic information and certain medical conditions that  
18 are identified by diagnosis codes and grouped into  
19 hierarchical condition categories, or HCCs.

20           Demographic information is tracked by CMS, but  
21 diagnosis codes are submitted by MA plans through encounter  
22 data, which are records of items and services that each MA

1 plan has provided to their employees.

2 MA plans have a financial incentive to document  
3 more diagnosis than providers in fee-for-service Medicare,  
4 leading to higher MA risk scores and greater Medicare  
5 spending when a beneficiary enrolls in MA. Our March  
6 chapter includes a discussion of the ways MA plans document  
7 diagnoses, such as chart reviews and in-home health risk  
8 assessments, which are generally not used in fee-for-  
9 service Medicare.

10 For 2021, we found that MA risk scores were about  
11 10.8 percent higher than fee-for-service beneficiaries with  
12 comparable health status. The Secretary is mandated by law  
13 to reduce MA risk scores to account for the impact of  
14 coding differences. However, this adjustment of 5.9  
15 percent only partially offsets the full impact. The  
16 remaining difference caused 2021 MA risk scores to be 4.9  
17 percent higher, generating about \$17 billion in payments to  
18 MA plans in excess of what Medicare would have spent for  
19 the same beneficiaries in fee-for-service.

20 In 2016, the Commission recommended a change to  
21 the coding intensity adjustment that would address both  
22 excess payments and the competitive advantage that some MA

1 organizations have due to coding. The Commission's  
2 strategy first focuses on addressing the underlying causes  
3 of coding intensity by removing health risk assessments  
4 from the risk adjustment and using two years of data to  
5 improve diagnostic documentation and then applying a flat  
6 adjustment to account for any remaining effect of coding  
7 intensity.

8           Since making our recommendation, the OIG has  
9 highlighted MA plans' use of chart reviews and health risk  
10 assessments. Based on OIG findings, we calculate that  
11 nearly two-thirds of MA coding intensity is due to chart  
12 reviews and health risk assessments.

13           Furthermore, MA plans use health risk assessments  
14 and chart reviews to differing degrees, which contributes  
15 to variation in coding intensity across MA plans and  
16 organizations.

17           Eliminating these underlying causes is a  
18 necessary component of fully addressing the effects of MA  
19 coding intensity.

20           The coding intensity estimates presented so far  
21 today have been published in prior MedPAC reports and are  
22 based on MedPAC's original cohort method, which is

1 described here using 2021 as an example. The method  
2 compares MA and fee-for-service cohorts with the same age,  
3 sex, and enrollment length. MA or fee-for-service  
4 enrollment as determined in 2021, and the length of  
5 enrollment includes all prior years of continuous  
6 enrollment in the same program, MA or fee-for-service. The  
7 method excludes beneficiaries with ESRD or institutional  
8 status, and it constrains new enrollees to have no coding  
9 intensity because these enrollees have a risk score that is  
10 based only on demographic factors.

11 The method analyzes changes in a beneficiary's  
12 disease score, which is a risk score minus the demographic  
13 components. For each cohort, we calculate the average  
14 change in disease scores between the earliest year of the  
15 enrollment cohort and 2021. Then for cohorts with the same  
16 age, sex, and enrollment length, we subtract the fee-for-  
17 service change in disease score from the MA change.

18 Finally, we sum the difference in the MA and fee-  
19 for-service disease score changes across all the cohorts  
20 waiting by MA enrollment, and then we divide by the average  
21 2021 MA risk score. The estimate represents the percent of  
22 MA risk scores that is attributable to coding intensity.

1           This figure shows coding intensity based on  
2 MedPAC's original cohort method over time. Our method has  
3 found that MA coding intensity generally increases by about  
4 1 percentage point per year, except in 2014, 2016, and 2017  
5 when CMS phased in a new risk score model designed to  
6 decrease coding intensity, and the agency implemented a new  
7 diagnostic coding standard.

8           Several independent studies about -- using a  
9 variety of methods and data sources generally corroborate  
10 our findings about the size of MA coding intensity.

11           We recently undertook a critical assessment of  
12 our cohort method and identified two areas for improvement.  
13 One improvement is to account for differences in MA and  
14 fee-for-service Medicaid eligibility. Since 2014, the  
15 shares of MA enrollees eligible for full or partial  
16 Medicaid benefits has increased, while the shares of fee-  
17 for-service beneficiaries eligible for such benefits has  
18 declined.

19           The second improvement is to remove the  
20 restriction that beneficiaries must remain enrolled in the  
21 same program, MA or fee-for-service. Under the original  
22 method, more early years of enrollment were truncated by

1 this restriction for MA enrollees, causing some bias in our  
2 analysis.

3 Under the revised method, we assign beneficiaries  
4 to MA or fee-for-service based on their 2021 enrollment but  
5 determine their enrollment length based on prior continuous  
6 enrollment in Medicare Parts A and B, with no consideration  
7 of prior MA or fee-for-service enrollment or switching  
8 between the two programs.

9 After implementing both improvements, we found  
10 that the revised coding estimates shown by the orange  
11 dashed line were somewhat larger than our published  
12 estimates for all years, with larger differences in more  
13 recent years.

14 For 2021, our coding intensity estimate was 13.2  
15 percent using the revised cohort method compared to 10.8  
16 percent using our original method. We found that the  
17 change in estimates was primarily due to removing the  
18 restriction requiring continuous enrollment in the same  
19 program. Accounting for differences in Medicaid  
20 eligibility had little effect on its own, but it  
21 contributed to a joint effect with removing the restriction  
22 on beneficiaries remaining in same program. That is

1 because beneficiaries eligible for Medicaid are allowed to  
2 switch Medicare enrollment outside of the annual election  
3 period, and Medicaid-eligible beneficiaries switch between  
4 fee-for-service and an MA plan more often than  
5 beneficiaries who are not eligible for Medicaid.

6 We now turn to our assessment of the Demographic  
7 Estimate of Coding Intensity, or DECI method. The DECI  
8 method uses the formula shown on the right side of the  
9 slide. Coding intensity is defined as the ratio of the MA  
10 to fee-for-service CMS-HCC risk scores over the ratio of  
11 the MA to fee-for-service demographic-only risk scores.

12 Authors Kronick and Chua published DECI estimates  
13 that are double MedPAC's original coding estimates. Their  
14 estimates rely on public CMS-HCC risk score information  
15 because beneficiary-level risk score data are not available  
16 to researchers.

17 Looking at the table on the left, second column  
18 from the right, the authors calculate an MA to fee-for-  
19 service CMS-HCC risk score ratio of 1.179 and an MA to fee-  
20 for-service demographic risk score ratio of 0.975. By  
21 taking the ratio of these, the authors calculate a coding  
22 intensity estimate of 20 percent for 2019.



1           This figure shows the DECI estimates published by  
2 Kronick and Chua. As shown in the last slide, their  
3 estimate is 2019 -- for 2019 is 20 percent. The first set  
4 of analyses we conducted on the DECI method implemented the  
5 method in the same way as described on the previous slide  
6 but used complete beneficiary risk score information.

7           This table shows the calculating leading to  
8 Kronick and Chua's 2019 estimate of 20 percent and adds  
9 calculations leading to our estimate of 13.2 percent when  
10 using complete data. The primary reason for the difference  
11 in the two estimates is highlighted in yellow. Kronick and  
12 Chua used a publicly available fee-for-service CMS-HCC risk  
13 score of 1.069, which includes about 5 million  
14 beneficiaries with Part A only. Whereas, all other risk  
15 scores in this analysis are limited to beneficiaries with  
16 both Part A and Part B.

17           Part A only beneficiaries are generally new  
18 enrollees who have lower risk scores than those with both  
19 Part A and B. We estimated a fee-for-service CMS-HCC risk  
20 score of 1.117 when restricting our analyses to  
21 beneficiaries with both parts A and B.

22           Kronick and Chua's lower fee-for-service CMS-HCC

1 risk score generates higher MA to fee-for-service ratio and  
2 a higher DECI estimate, and it accounts for about 80  
3 percent of the difference in the two estimates.

4           The remaining difference, highlighted in red, is  
5 due to our ability to more accurately identify Medicaid  
6 eligibility and institutional status. As a result of this  
7 difference in data, Kronick and CHUA calculate a slightly  
8 lower MA to fee-for-service demographic risk score ratio,  
9 which contributes to their higher DECI estimate.

10           Next, we identified two improvements to the DECI  
11 method. First, we accounted for differences in MA and fee-  
12 for-service Medicaid eligibility and institutional status,  
13 and second, we constrained new enrollees to have no coding  
14 intensity, as their risk scores are not dependent on  
15 diagnosis codes.

16           To do this, we calculated separate DECI estimates  
17 for the five groups of beneficiaries shown in the slide:  
18 new enrollees, beneficiaries with institutional status, and  
19 beneficiaries with no partial or full Medicaid benefits.  
20 Then we summed the group estimates weighted by the MA  
21 enrollment share. These revisions reduced our 2019  
22 estimate by an additional 1.8 percentage points to 11.4

1 percent.

2           This slide summarizes the effects of using  
3 complete risk score data and revising the DECI method.  
4 Starting from Kronick and Chua's 20 percent estimate for  
5 2019, we find that the largest effect, a 5.6-percentage-  
6 point reduction, is due to restricting the fee-for-service  
7 CMS-HCC risk scores to beneficiaries with Part A and Part  
8 B. More accurate identification of Medicaid eligibility  
9 and institutional status reduces the estimate by an  
10 additional 1.2 percentage points.

11           For the two revisions to the DECI method,  
12 constraining new enrollees to have no coding intensity  
13 further reduces the estimate by 1.1 percentage points, and  
14 accounting for differing shares of Medicaid eligibility or  
15 institutional status reduces the estimate by 0.7 percentage  
16 points more.

17           We replicated our revised DECI method using  
18 complete data in all years and found consistently lower  
19 DECI estimates, indicated by the dashed teal line. Revised  
20 DECI estimates are about 5 to 8 percentage points lower  
21 than Kronick and Chua's estimates, except for 2014 through  
22 2016, where the impact of our revisions is either lower or

1 higher than in the other years.

2 As shown in the previous slide, the DECI estimate  
3 for 2019 was reduced from 20 percent to 11.4 percent when  
4 using the revised DECI method with complete data.

5 This figure compares estimates based on the four  
6 coding intensity estimation methods discussed today. By  
7 using complete data and revising both methods, we have  
8 essentially reconciled the differences in the two methods.

9 Continuing with the 2019 from the previous slide,  
10 we now add the revisions to MedPAC's cohort method,  
11 increased that coding intensity estimate from 9.1 percent  
12 to 11.0 percent, which is only 0.4 percentage points lower  
13 than the revised DECI estimate for 2019.

14 The two dashed lines show that MA coding  
15 intensity estimates based on the revised DECI and revised  
16 MedPAC cohort methods are within 1 percentage point for all  
17 years after 2017.

18 Finally, we discussed the coding intensity  
19 estimates for 2021. In the remaining slides, we will  
20 discuss adopting the revised DECI method with complete data  
21 to estimate MA coding intensity in future MedPAC work. In  
22 doing so, we would revise our prior coding intensity

1 estimates.

2           For example, our 2021 coding intensity estimate  
3 would change from 10.8 percent under MedPAC's original  
4 method to 14.1 percent under the revised DECI method.

5           Given that we were able to reconcile differences  
6 in the two methods of estimating coding intensity, we  
7 conclude that using complete data and incorporating the  
8 revisions discussed today, both methods can produce  
9 accurate estimates of MA coding intensity. However, we  
10 find that the DECI method is easier to implement. MedPAC's  
11 cohort method requires calculating disease scores for all  
12 beneficiaries in all years since 2007, and it requires a  
13 large and increasing number of sub-cohorts based on age,  
14 sex, Medicaid eligibility, and enrollment length.

15           Furthermore, the DECI method includes  
16 beneficiaries with institutional status and years of  
17 partial enrollment, which are excluded from MedPAC's cohort  
18 method.

19           Therefore, we believe that using the revised DECI  
20 method to estimate the impact of coding intensity in  
21 MedPAC's future work would provide accurate estimates of MA  
22 coding intensity and would be easier to implement than

1 MedPAC's revised cohort method.

2           Looking again at 2021, we describe the impact of  
3 adopting the revised DECI method on MedPAC's work. As  
4 noted earlier and in prior MedPAC reports, using our  
5 original cohort method, we found that MA coding intensity  
6 was 10.8 percent. After accounting for the 5.9 percent  
7 adjustment, we found that uncorrected coding intensity  
8 increased MA risk scores by 4.9 percent. If adopting the  
9 revised DECI method, we would conclude that 2021 MA coding  
10 intensity was 14.1 percent. And after accounting for the  
11 5.9 percent adjustment, we would conclude that uncorrected  
12 coding intensity MA risk scores -- increased MA risk scores  
13 by 8.2 percent.

14           After adopting the revised DECI method, we would  
15 similarly revise coding intensity estimates for all prior  
16 years.

17           During the discussion, I'll answer questions  
18 about the revisions to and analyses of the methods to  
19 estimate coding intensity presented today. We welcome  
20 feedback about the strengths and weaknesses of using the  
21 revised DECI method for estimating the impact of MA coding  
22 intensity in future MedPAC analyses, and now I'll turn it

1 back to Mike.

2 DR. CHERNEW: The fact that you did stuff and got  
3 two lines to almost overlap is just astounding. This is a  
4 general analytic point but, in any case, fascinating. So I  
5 will leave it there.

6 We do have a Round 1 queue, and I think it is  
7 going to be kicked off by -- Stacie?

8 DR. DUSETZINA: Thanks. You said that with a  
9 lack of confidence, Mike.

10 [Laughter.]

11 DR. CHERNEW: I'm not saying anything useful. I  
12 had in my mind that you were later in the queue, but then I  
13 looked, and you are, in fact, first.

14 DR. DUSETZINA: I hardly ever have Round 1  
15 questions, but in this case, I did have a question about  
16 the enrollment change. And I guess it's two questions.

17 One is I didn't see anything about how censoring  
18 could happen, like if a person died. Do they have to be in  
19 for the full year?

20 And the other part of that question was you give  
21 an example of somebody in Medicare fee-for-service for two  
22 years, and then they go over to MA. If that had been

1 reversed, would you count those two years like in your  
2 analysis for the MA part?

3 DR. JOHNSON: So in both the original method and  
4 the revised method, we start with the most recent year,  
5 2021, and then look backwards, and so if the beneficiary in  
6 the original method was in MA and had parts A and B for  
7 2020, they'd be included in there and the same for 2019  
8 until they get to a year where they were either not in  
9 Medicare or not in MA or didn't have A and B.

10 In the example, the beneficiary joins fee-for-  
11 service first for two years, then switches to MA and stays  
12 in MA through 2021, under the original method, we just  
13 counted the MA portion of that enrollment. Under the  
14 revised method, we wouldn't consider the change to MA and  
15 fee-for-service. We'd look at the two years prior and  
16 include their whole history.

17 And I think you asked if the enrollment was  
18 reversed. That beneficiary would be in the fee-for-service  
19 cohort because of their 2021 fee-for-service enrollment,  
20 and the same would apply the original method. It would go  
21 back to their earliest fee-for-service enrollment, and the  
22 revised method would add their earlier Medicare enrollment.



1 DR. DUSETZINA: Okay. So then neither of those  
2 methods taken would allow for people who died because  
3 you're starting with the people who are alive --

4 DR. JOHNSON: That's right.

5 DR. DUSETZINA: -- and then just looking back.

6 DR. JOHNSON: Yes.

7 DR. DUSETZINA: Okay.

8 And then I promise this is not sarcastic, but on  
9 page 5, you said that the 5.9 percent adjustment is in  
10 place until the Secretary implements risk adjustment. Do  
11 we think that's ever going to happen, or was that sort of  
12 just a we think that's a -- I was like maybe that'll happen  
13 soon, or maybe that's supposed to happen?

14 DR. JOHNSON: That's mostly a recitation of what  
15 the law says, and that once -- if the Secretary implements  
16 risk adjustment using basically the encounter data, the MA  
17 data, then the coding intensity adjustment would no longer  
18 apply.

19 DR. DUSETZINA: Okay, great. Thanks.

20 MS. KELLEY: Brian.

21 DR. MILLER: So I feel like I'm having fun on my  
22 first public meeting because it's like an MA party, which

1 is one of my favorite topics to read about. So the answer  
2 is normally I don't have such pressured speech.

3           So a couple questions. One, I think this was a  
4 good citation and sort of adaptation of Kronick's work. I  
5 guess my question and broader for MedPAC is, do we think  
6 that we should adopt a new coding intensity method based  
7 upon the work of primarily one academic economist? Because  
8 when I looked at the citations on page 7, there were four  
9 papers and one CRB brief driven by Kronick's work, and I  
10 worry about us anchoring on one econometric expert for  
11 deciding coding intensity for a \$450 billion-a-year  
12 program. So I would go broader in the academic literature  
13 in addition to comparing to our prior methods.

14           I think the other thing that we should do, which  
15 will probably give us heartburn, but we should do it anyway  
16 in the interest of transparency, is we should compare  
17 MedPAC's historical method for coding intensity adjustment  
18 to Kronick's, to various other academics' coding intensity  
19 adjustments, and to industries.

20           I read all kinds of industry documents from every  
21 trade association. I often do not believe many of them or  
22 I disagree with the analysis, but I still read them and

1 respond to them. So I think we should do that as a matter  
2 of routine.

3 Another thing that I think should be in here is  
4 that there should be some sort of adjustment for under-  
5 coding and fee-for-service.

6 And then I think there's an important  
7 intellectual concept for coding intensity that MedPAC  
8 hasn't really addressed historically, and that I view  
9 coding intensity as having three components. One is  
10 clinically appropriate coding intensity, which if you -- I  
11 looked at that 2018 Inquiry paper that you cited, which was  
12 great, which found that coding intensity is actually  
13 greater for HMOs, which is something that we would expect  
14 from true integrated care delivery with a narrow network.

15 Then there's what I would call "abusive coding  
16 intensity," which we don't want, which is blowing -- you  
17 know, setting taxpayer money on fire potentially, which is  
18 bad.

19 And then there's the third one, which is fraud,  
20 and fraudulent coding intensity is what we don't want. And  
21 that results in a nice visit from the Department of  
22 Justice.

1           So I think that we should differentiate between  
2 those three types of coding intensity.

3           And then I just worry -- I'm not an economist,  
4 but I worry about the removal of the restriction of  
5 requiring continuous enrollment.

6           DR. JOHNSON: One comment on some of the other  
7 academic literature, some of the studies out there use  
8 other data sources because the risk score data are not  
9 available, and so we look at those and find them helpful,  
10 that they generally corroborate the size. But I don't  
11 think many of those methods would be the preferred method  
12 if the full risk score data was available.

13           And then I think essentially there's the Kronick  
14 and CHUA method and the MedPAC method are really the only  
15 two proposed methods -- oh, I guess there is CMS's original  
16 method that implemented in 2010 -- the three that have been  
17 discussed as ways to estimate the size of encoding  
18 intensity with the intent of putting into some policy  
19 action, actually.

20           DR. MILLER: To be clear, not criticizing, it's  
21 more for our defensibility, because this is such a big  
22 issue, if we go through all of the options that are out

1 there, even if we think they're terrible, then it's a more  
2 defensible recommendation for us in the long term.

3 MS. KELLEY: Robert.

4 DR. CHERRY: Yeah. Thank you. Very good report.

5 And I just had a clarifying question around the  
6 disease score, because you mentioned disease scores, the  
7 risk score minus the demographic components, and it wasn't  
8 perfectly clear to me what the demographic components are.  
9 The reason why I'm asking, because I was curious to know if  
10 the demographic components included geocodes, because  
11 geocodes can be really useful in taking a population and  
12 differentiating them from least vulnerable to most  
13 vulnerable from a health care disparities perspective. So  
14 it could be useful in the overall calculation of the  
15 disease score, so just curious what those demographic  
16 components were.

17 DR. JOHNSON: Mainly, they are each beneficiary  
18 has one coefficient based on their age and sex category.  
19 So those are removed. And then depending on the year of  
20 risk score, some of the models have a separate Medicaid or  
21 originally disabled adjustment, and those are what's  
22 removed. So what remains is any of the components of the

1 risk score that are based on the HCCs and diagnoses,  
2 including some of the interaction terms where it's having  
3 multiple HCCs. So there aren't any of the geocodes  
4 included in that risk score.

5 DR. CHERRY: I'm sorry. I didn't catch that.

6 DR. JOHNSON: And there aren't geocodes included  
7 in that.

8 DR. CHERRY: Thank you.

9 DR. NAVATHE: Andy, I have what is hopefully a  
10 quick question. So in the table where you basically update  
11 the DECI method, you note that there's this 1.1 percent  
12 adjustment for new enrollees, and I read and re-read it.  
13 And I just couldn't understand where that difference is  
14 coming from. What is the original DECI method doing that's  
15 assigning a non-zero score to new enrollees? Is it a  
16 subset of beneficiaries who have prior fee-for-service  
17 data? I'm just trying to understand that better.

18 DR. JOHNSON: So starting with our method, we  
19 look at people who are not new enrollees, who have some  
20 history of coding intensity and estimated on that portion  
21 of the population. But the 5.9 percent adjustment is  
22 applied to the full population, and so we basically say

1 there's 90 percent of the population, we have a risk score  
2 estimate of X, but 10 percent is new enrollees. The  
3 adjustment still applies to them, and so we reduce that,  
4 basically take the weighted average of the 10 percent with  
5 zero coding intensity and 90 percent. And the reason is so  
6 that it is when the adjustment is applied to everybody is  
7 there.

8           In the DECI method, it's the MA to fee-for-  
9 service ratio of CMS risk scores and the same ratio of the  
10 demographic risk scores. There are new enrollees included  
11 in that ratio, and so if you separate them out from the  
12 rest of the people, we found that in 2019, the coding  
13 intensity effect of just the new enrollees was 1.1 percent,  
14 and really, we think that should be zero where those new  
15 enrollees don't exhibit any risk score or any coding  
16 intensity.

17           DR. NAVATHE: Thanks.

18           MS. KELLEY: Cheryl.

19           DR. DAMBERG: I have a question on page 13, where  
20 you talk about your two revisions, and this is about  
21 Medicaid benefit eligibility. So I was wondering, did you  
22 also consider, in addition to Medicaid, looking at whether

1 somebody has a low-income subsidy because of the state  
2 variation in eligibility for Medicaid?

3 DR. JOHNSON: We didn't, and primarily, it's  
4 because since 2017, the risk model has separate segments  
5 for no Medicaid eligibility, partial and full, and so we  
6 are replicating basically that a beneficiary who has the  
7 same set of HCCs and demographic information could have a  
8 different risk score if they're a full benefit, partial  
9 benefit, or no benefit. So we're sticking to those, that  
10 distinction, because it's the way it's included in the risk  
11 model.

12 MS. KELLEY: Jaewon.

13 DR. RYU: I had a quick question about the  
14 comparison cohort within fee-for-service. Was there any  
15 consideration in any of these methodologies around how many  
16 or if any were in ACO programs?

17 DR. JOHNSON: We have not looked at the ACO  
18 programs.

19 I know there often is an idea that that should be  
20 increasing the fee-for-service rate of risk score growth.  
21 We haven't found, at least relative to the MA growth, a  
22 meaningful change due to the ACOs.



1           Some speculation is that ACOs have incentives to  
2 increase risk scores and do coding, but they don't quite  
3 have all the tools that the MA plans have, like chart  
4 reviews and in-home risk assessments or some of the other  
5 programs that MA plans tend to use.

6           DR. RYU: Well, and they're capped, right?

7           DR. JOHNSON: Yeah, and they're capped.

8           DR. RYU: So dampened incentives maybe.

9           DR. JOHNSON: Yes, right.

10          MS. KELLEY: Tamara.

11          DR. KONETZKA: We're on Round 2 now or not?

12         Because I had a Round 1, so --

13          MS. KELLEY: Gina.

14          MS. UPCHURCH: Thanks.

15                 Just to quickly follow up on Amol's question, I  
16 understand that agents and brokers can make up \$600 when  
17 they sign up somebody new for a Medicare Advantage plan if  
18 they stay on for three months. So do you think that's what  
19 that -- is that why we think there might have been an  
20 adjustment in the other method, but MedPAC is not choosing  
21 to use it? Is it an incentive to get newer people on to  
22 Medicare, new 65-year-olds on to Medicare Advantage plans?

1 Is that what they're adjusting for?

2 DR. JOHNSON: I don't think so, though I have  
3 heard of that incentive for brokers and agents, but I don't  
4 think that's quite related to what the method is trying to  
5 capture.

6 MS. UPCHURCH: Okay. Thanks.

7 MS. KELLEY: That's all we have for Round 1.

8 DR. CHERNEW: And if I have this correct, Kenny  
9 has sent a comment for Round 2.

10 MS. KELLEY: Yes. And so I will read it. Kenny  
11 says great, insightful analysis, Andy. Thank you.

12 He'd like to raise three issues: unintended  
13 policy impact, better understanding of the CMS-MedPAC  
14 metric differential, and the potential shortcoming of the  
15 revised cohort method.

16 First, regarding unintended policy impact, he  
17 suggests that we be careful about the unintended policy  
18 implications of retrospective analysis that treats MA in a  
19 static market -- as a static market while not considering  
20 upcoming intended prospective CMS risk model changes, which  
21 would negatively impact market dynamics.

22 CMS's latest risk model change, phased in from

1 2024 to 2026, has the effect of a coding intensity  
2 adjustment, which will significantly reduce the frequency  
3 of conditions that are coded more frequently and/or  
4 accurately in MA relative to fee-for-service.

5           In addition to this headwind, MA plans are  
6 struggling with a tougher RADV rule and headwinds from  
7 well-publicized higher medical costs and negative margin  
8 impacts from the Inflation Reduction Act of 2022.  
9 Consequently, plans had to previously explore benefit  
10 reductions and/or rising beneficiary premiums from all  
11 these headwinds.

12           We need to be mindful of not squeezing the  
13 balloon too tight by suggesting additional rate cuts from  
14 coding intensity adjustments, which may not be justified,  
15 until it blows up in our face, thereby endangering  
16 beneficiary access, resulting in small plan exits and  
17 significantly greater health plan consolidation.

18           Finally, MA is not a monolith, as there is a  
19 heterogeneity of coding practices which vary significantly  
20 by health plans, as prior MedPAC reports have suggested.  
21 Therefore, Kenny suggests that any coding intensity  
22 recommendation be tiered by health plans.

1           Regarding a deeper understanding of the  
2 differences between MedPAC and CMS on coding intensity,  
3 he's intrigued that while we are able to replicate the CMS  
4 fee-for-service risk score from 2017 to 2019, he's more  
5 than surprised at the huge difference between MedPAC  
6 estimated current proposed of 11 to 13 percent versus CMS's  
7 previously published numbers.

8           For the next iteration of this analysis, he's  
9 wondering if more light can be shed on the likelihood of  
10 the following potential drivers of the differential and how  
11 it could have been used for the computation; the rapid  
12 growth of MA versus fee-for-service -- the fee-for-service  
13 risk score is understated -- risk model changes beyond an  
14 averaging method; Medicaid noise impacts, specifically  
15 mixed noise impact of D-SNPs.

16           And a follow-up question on Medicaid, if we think  
17 about the MA landscape, about 65 percent are conventional  
18 individual MA enrollees, 15 percent are in employer plans,  
19 and 20 percent in special needs plans. Kenny conjectures  
20 that Medicaid could have a larger impact than what our  
21 model had estimated. Would it be possible to assess how  
22 the coding intensity could change if we did the analysis

1 just for conventional individual MA enrollees?

2           And then regarding the revised cohort method,  
3 based on Kenny's understanding of the reading, he  
4 conjectures that the revised cohort method may possibly  
5 result in potential overstatement of the metric for chronic  
6 beneficiaries who joined MA, switched to fee-for-service,  
7 and then revert back to MA. Can we illustrate this with an  
8 example in the next follow-up to this analysis to test this  
9 hypothesis, as a majority of MA beneficiaries have chronic  
10 conditions?

11           And then I have Robert next.

12           MR. MASI: Sorry. Real quick, Dana. Could I  
13 jump in for one moment?

14           MS. KELLEY: Yes. of course. I'm sorry I missed  
15 you.

16           MR. MASI: So I just wanted to thank Kenny for  
17 surfacing the risk model change, and we'll have that on our  
18 mind as we go about our MA work, particularly on the status  
19 update later this year. So I wanted to be responsive to  
20 that.

21           And then, secondly, around the comparison between  
22 the CMS measure of coding intensity and MedPAC measure --

1 and here, I'm looking closely at Andy, who should jump in  
2 at any point -- I'm not sure -- I was wondering if we could  
3 help clarify some concepts here. I'm not sure that CMS has  
4 published a comparable measure of aggregate coding  
5 intensity between MA and fee-for-service. I think instead  
6 they published some information around changes in risk  
7 scores from year to year.

8 But at this point, I've said too much, and I want  
9 to see if Andy wants to add or edit anything.

10 DR. JOHNSON: I think that's right, and it is a  
11 common question. I think, conceptually, CMS is measuring  
12 the trend in MA risk score changes and reporting it in  
13 their fact sheet and the advanced notice in the  
14 announcement.

15 If you were to compare that to our method, the  
16 cohort method, if you looked at the difference in the trend  
17 in MA and fee-for-service year to year and then you  
18 aggregated across all of the years, we are estimating sort  
19 of a level effect into 2021 in the most recent year, but  
20 the CMS number is really just an MA risk score growth rate  
21 estimate for one year to the next.

22 MR. MASI: Thank you.

1 DR. CHERNEW: MA risk score change for one year.

2 DR. JOHNSON: Yes. The growth, yeah.

3 MS. KELLEY: Robert.

4 DR. CHERRY: Yeah. Just a few comments. One, I  
5 want to follow up to my R1 question, and it's in the  
6 context of all the, I think, robust discussion that we had  
7 around the safety net index during the last year. I think  
8 it would be a good idea to see if we could introduce  
9 geocodes or something comparable so that we understand  
10 coding intensity from the perspective of vulnerable  
11 populations, because they tend to be sicker. And the  
12 coding intensity there may be appropriate, and so there may  
13 be a need for some adjustments based on vulnerable  
14 populations in the context of our safety network that was  
15 done.

16 The other thing I'll mention is I'm glad we're in  
17 sort of an analytical phase right now because I think it  
18 will take some time to come up with recommendations around  
19 the work that you're doing.

20 I also am encouraged by the fact that we're  
21 discussing this in terms of parity between MA programs and  
22 fee-for-service and even between MA programs in terms of

1 coding intensity. I think for the very similar reasons  
2 that Brian mentioned, because -- and maybe we're being  
3 physician-centric, because when we hear about coding  
4 intensity, we're thinking about fraudulent coding. And so  
5 thinking about it in terms of parity, I think, is a good  
6 step forward.

7           Where I struggle with is what precedes coding  
8 intensity. What precedes coding intensity is really  
9 accurate and complete documentation, and putting my quality  
10 hat on, accurate and complete documentation is absolutely  
11 essential for performance improvement work, for quality and  
12 safety. It also accurately documents, and you're able to  
13 abstract the disease burden on your patient population and  
14 also develop solutions based on that disease burden that  
15 helps to reduce or mitigate potential solutions for social  
16 determinants of care. And also, accurate and complete  
17 documentation is a very important communication tool for  
18 interprofessional multidisciplinary care.

19           So I think we also have to remember that the  
20 documentation piece is closely correlated with coding  
21 intensity, and that as we start to go through the analytics  
22 and start to pivot towards recommendations, we need to be a



1 bit cautious about penalizing for complete and accurate  
2 documentation but develop solutions around charting that  
3 bring parity without driving up costs. So there's a little  
4 bit of a balancing act here that I think we need to be  
5 cognizant of.

6           Otherwise, great work, and I'm sure we're going  
7 to be talking about this for quite a while, so thank you.

8           DR. CHERNEW: I may or may not have said this  
9 earlier. I just want to -- that's the second time Kenny  
10 said a somewhat similar thing. This is largely a  
11 measurement exercise. We will at some point get to a  
12 recommendation, although not this cycle on this, but we're  
13 not -- this is not moving -- however this plays out is not  
14 moving to a revision of the set of MA recommendations that  
15 we have, at least not in this cycle. It's just there's  
16 been a lot of back-and-forth in the world about this  
17 magnitude of any coding and, for that matter, selection  
18 differences. And this is just a methodological point about  
19 how to quantify that.

20           The issue of what we do, which I understand is  
21 actually probably a more important point, but that's -- so  
22 yay. But that's going to be a little bit outside of this.

1 We aren't saying, oh, because you've done this, Andy, now  
2 we're going to go change our recommendations, or at least  
3 we're not going to do that yet. So that's just a level-  
4 setting of where this is fitting into the work plan.

5 Is that --

6 DR. CHERRY: Agreed.

7 MS. KELLEY: Brian.

8 DR. MILLER: Thank you.

9 And I said this is excellent work, and it's not  
10 easy to do this chapter. I recognize it was very dense,  
11 very well written. I read it several times, and I still  
12 had a headache, not from the chapter but because this is  
13 just hard stuff.

14 So thinking about it, I'm also interested in  
15 solutions, because I've been hearing about coding intensity  
16 since I was in medical school, and I'm no longer as young  
17 as I used to be. So it's a double-digit amount that I've  
18 been hearing about it and reading about coding intensity.

19 And so I'm thinking about solutions that maybe we  
20 could consider as part of the work about measuring coding  
21 intensity, one, and potentially answering rather than  
22 continuing to revise econometric methods to measure coding

1 intensity to determine exactly what the coding intensity is  
2 and then address it.

3           So coding intensity is on the order of tens of  
4 billions a year, depending upon who we ask. That's a lot  
5 of money. Why not think about using AI to crawl charts or  
6 diagnosis codes in MA and fee-for-service for a comparison  
7 as one answer?

8           Another potential answer as food for thought, if,  
9 for example, we believed the Kronick estimate of 20 percent  
10 is real -- seems high to me, but if we do believe that is  
11 real, that also tells us, as Robert said, that fee-for-  
12 service coding maybe isn't so hot, and we should  
13 potentially invest in educating providers about coding  
14 appropriately. And I'm not suggesting that we do the 1-  
15 800-Medicare one.

16           And then I would say that the final answer is, if  
17 it really is tens of billions of dollars, it might actually  
18 be worthwhile for us to suggest that Congress appropriate a  
19 hundred million or whatever millions of dollars it costs to  
20 do a chart audit of a large population in MA and fee-for-  
21 service and construct diagnosis coding from scratch and see  
22 how that compares to what is actually modeled and billed.

1 DR. CHERNEW: So I'm going to ask a clarifying  
2 question on the basis of that. I think this is important,  
3 and I think you said this, Andy. I think the number is  
4 roughly two-thirds of the difference. It is not because  
5 the codes that the providers are putting in are differing  
6 between MA and TM. It's because MA is adding on top of the  
7 data that fee-for-service has. It's a new set of data  
8 coming from a different source, health risk assessments,  
9 which is not available in fee-for-service.

10 So the distinction in the parity, at least,  
11 again, is not simply, okay, let's just see what's happening  
12 in the codes that are coming out. It's this differential  
13 armament that MA plans have to code that fee-for-service  
14 doesn't.

15 DR. MILLER: May I respond?

16 DR. CHERNEW: Please.

17 DR. MILLER: So I think part of the challenge  
18 around health risk assessments also is something that's  
19 worth addressing specifically as an operational.

20 So first, from the coding answer, if you go back  
21 far enough, you can find many of those diagnoses that you  
22 probably get on an HRA, if you go far enough back into the

1 records. And that's what I mean by doing a chart audit as  
2 opposed to just a claims audit.

3 And then, secondly, I know that there's a lot of  
4 controversy on HRAs. We can also consider requiring that  
5 if an HRA is done, that it be a clinically meaningful  
6 visit, and that could be a recommendation that would make  
7 it a functional visit as opposed to just diagnosis code  
8 harvesting.

9 DR. CHERNEW: So we will continue this  
10 discussion, but, Andy, is it correct that the problem is at  
11 least in part where the data is coming from, not that the  
12 same data is different?

13 DR. JOHNSON: Yes. That is based on our  
14 calculations from the OIG numbers where they looked at  
15 chart reviews and in-home health risk assessments that  
16 generally are not provided in fee-for-service Medicare.

17 DR. CHERNEW: We should keep going.

18 MS. KELLEY: Jonathan had something on this  
19 point.

20 DR. JAFFERY: Yeah. Thanks, Dana.

21 So I'm very much in support of the concept of  
22 trying to do something systematically that would take this

1 out of the hands of the plans or the individual providers  
2 and do it uniformly across both MA and fee-for-service.  
3 So, Brian, I like that overall direction.

4 I have some concerns. I don't know if AI is  
5 something that would be useful at this point, and "AI" is  
6 used as a term very broadly right now. But I do have some  
7 concerns about making sure we don't memorialize or worsen  
8 disparities, especially if we're having people who don't  
9 come into the clinic regularly or if we're not going to  
10 capture social risk and things like that.

11 And then, finally, the idea -- just to share an  
12 experience, the idea of training docs, for those who don't  
13 know, I spent a lot of time running a big ACO and invested  
14 in this. And there's a whole cottage industry that has  
15 come up around HCC coding, and so there's tools. There's  
16 EMRs that help, that don't help, and it's very difficult  
17 for me to conceive of CMS taking this task on for  
18 physicians across the country. It's just a big complex  
19 ball game there.

20 Thanks.

21 MS. KELLEY: Okay. The next commenter is Greg,  
22 so I will read his comment. Greg is supportive of this

1 report, both its objectives and approach. He also realizes  
2 that this is not a recommendation and that when the time  
3 comes, it will be placed into a broader context. However,  
4 since the tentative results that we discussed here have the  
5 potential to influence the perspectives of policymakers,  
6 potentially in the absence of the necessary context, he  
7 believes that we have a responsibility to highlight some of  
8 the contextual information throughout the process. For  
9 that reason, he thinks it is critical to add the following  
10 to the discussion and the record for this meeting.

11           The overall MA payment comparison to fee-for-  
12 service is important but must be considered in the context  
13 of the huge variability among participating MA plans.  
14 MedPAC's pre-publication review from March 2023 of last  
15 year noted that among MA plans, growth in 2021 risk scores  
16 ranged from below fee-for-service for some plans to 40  
17 percent above fee-for-service for plans at the other  
18 extreme.

19           This variability was highlighted by a Humbi  
20 research study that Kenny probably knows. It showed very  
21 large national carriers with risk scores, 17 percent higher  
22 than Blue Cross plans and community-based plans. This is

1 all the more important since these community plans often  
2 perform significantly better for Medicare beneficiaries.

3           A recent study commissioned by the AHA showed  
4 that integrated health plans, almost all local and  
5 relatively small, perform statistically better than others  
6 on 74 of 105 quality and value measures. In contrast, the  
7 other plans performed significantly better on only 7 of  
8 those 105 measures. We would certainly not want to punish  
9 those plans that perform well and code conservatively, and  
10 we must maintain this focus as we consider policy options  
11 that will address the reality of coding and risk adjustment  
12 equity challenges.

13           By the way -- and this is very relevant to the  
14 points Brian, Larry, and Cheryl made earlier regarding plan  
15 concentration -- risk adjuster and coding maximization  
16 appears to be very subject to national scale economies.  
17 There's excellent support for the belief that MA  
18 concentration is so much greater than Medicaid  
19 concentration in states that have managed Medicaid or  
20 exchange plan concentration, largely because so much money  
21 can be made through risk and coding maximization.

22           This should be no surprise. Coding maximization



1 is much easier to do at scale than the hard work of  
2 actually improving real value at the point of care. So the  
3 variation between MA plans coding must always be kept in  
4 mind as we examine gross variation between MA and fee-for-  
5 service.

6 And the next comment I have is from Tamara.

7 DR. KONETZKA: I've been debating if I really  
8 want to get into this fee-for-service discussion, but I'm  
9 going to say what I was thinking, because that was my  
10 strongest reaction when I was reading the chapter is why  
11 are we comparing everything to fee-for-service, and what  
12 does that mean?

13 I think it's clear that coding -- the term  
14 "coding intensity" was chosen for a reason, and it's not  
15 coding accuracy, but kind of consistent with some of the  
16 things Robert was saying, I think the accuracy part is  
17 really important. I'm not sure that just sort of working  
18 toward parity, if our comparison is not very good coding,  
19 serves a broader purpose, right? It's obviously designed  
20 for a certain purpose here, but there's this broader issue  
21 that apparently, even within MA, but also in fee-for-  
22 service that the coding may just not be very accurate. And

1 we may want to think more broadly. I know we're not making  
2 recommendations. We may want to think more broadly about  
3 how to improve coding while we try to improve parity,  
4 because just for care planning, for research, for so many  
5 reasons, the accuracy of the coding is just as important as  
6 the parity.

7 DR. CHERNEW: I agree with that, and first of  
8 all, if I have this correct, Dana, Tamara was the last  
9 person in Round 2. So that gives me a little bit more  
10 leeway for you guys to think about further kinds of  
11 comments or questions that you want to make on this  
12 chapter.

13 There's a distinction between what's coded and  
14 what's paid for. The problem -- and there's two separate  
15 problems which were very clearly outlined, I think, in  
16 Greg's comments, which is -- one of them is if it turns out  
17 that fee-for-service is bad -- and we can talk about making  
18 fee-for-service better, but if it turns out that fee-for-  
19 service is bad -- as I said before, I think fee-for-service  
20 is quite bad at the coding -- and MA is good, even if  
21 accurate, the calibration in our payment models is such  
22 that the MA payments are much higher.

1           And so the question, which is a reasonable one,  
2 is should we try and get fee-for-service coding better or  
3 MA coding worse? No one wants MA coding to be worse. It's  
4 just a question of paying differentially. That's all a  
5 level -- that's all level calibration, and there's a bunch  
6 of other policy issues like what benefits would be lost if  
7 you cut payments. So it's a bunch of other issues about  
8 how you respond to that particular thing, but it's really  
9 about the payment gap that is driven by improved coding,  
10 and that's a level issue.

11           Then there's the point that Greg made, which is  
12 there's also widespread heterogeneity across plans. So  
13 imagine we just adjusted within the MA plans, right? Then  
14 you're giving some plans more than others, which is a  
15 separate coding -- it's not a program expense issue,  
16 because you're just shifting the money around from the bad  
17 coders to the good coders. It's a separate problem, and I  
18 also think that's an issue.

19           But the core issue that this analysis feeds into  
20 is to answer a question that we are asked repeatedly, which  
21 is how much more do we pay, not how much more we get, not  
22 how much better it is, but just in a very simple budgetary

1 way, how much more do we pay for a Medicare Advantage  
2 enrollee relative to a fee-for-service enrollee? And what  
3 are the contributors to that gap? So there's other things,  
4 the quality program, a bunch of other things to talk about.

5           And this is one of several components that cause  
6 the payment gap to rise, and we get things for that payment  
7 gap. We could debate how much, but we get things for that  
8 payment gap. So this is why it ends up being a little bit  
9 more technical here, but no one is arguing that MA plans  
10 shouldn't do home assessments. The question is whether  
11 they should get paid for them when we're trying to  
12 calibrate to a group that doesn't have home assessments.  
13 We could discuss whether we should have fee-for-service  
14 home assessments or what I would call "whole-cloth changes"  
15 of how the system works. That's a bigger issue that has a  
16 whole bunch of other policy issues around the cost of it,  
17 the admin burden, would it work, and blah, blah, blah,  
18 blah, blah.

19           But right now, we're just trying to answer an  
20 analytic question about how comparable is the payment of MA  
21 and fee-for-service, and to what extent does the tendency  
22 of MA plans to record more diagnoses, either through paying

1 physicians to record them or by having separate tools like  
2 health assessments? That's kind of where we are. So I  
3 don't know if that was helpful to explain why it's not so  
4 much about -- I'm done now.

5 DR. NAVATHE: Can I make a point?

6 DR. CHERNEW: Paul is going to go next because  
7 he's been so good. I was joking, but yes, go ahead, Paul.

8 MR. MASI: I'll be quick, and then I'll turn it  
9 over to you, Amol.

10 So I'm going to do a hazardous thing, which is  
11 try to make a historical point during my first meeting. So  
12 I'll again look at Andy, and please jump in if as I get  
13 things wrong.

14 I just wanted to make one point about the  
15 importance of the distribution of coding intensity across  
16 different types of plans, and that's something that MedPAC  
17 has observed in the past. And my recollection is that our  
18 recommendations in the past have been responsive to that  
19 and have kept that in mind, and so I just wanted to say  
20 that the extent to which that's something that a number of  
21 Commissioners have surfaced and pointed to, that's also  
22 been on our radar and will continue to be.

1           Now Amol.

2           DR. NAVATHE: So I just wanted to partly respond  
3 to Tamara's point also because I think it's somewhat  
4 relevant here.

5           So I think I agree with what Mike said in terms  
6 of comparability point, but I think also if you take a step  
7 back and think about this as an insurance market, like the  
8 way that this Medicare Advantage, quote/unquote, "insurance  
9 market" is working, it's very different than a traditional  
10 group like employer-based insurance market.

11           When your or my employer goes and negotiates with  
12 whomever, they're not looking at our risk codes and  
13 deciding how much we get paid for Amol and Tamara and  
14 Robert and so forth, right? It's at a group level.

15           So the fact here that we're doing this at an  
16 individual level and mapping across fee-for-service to MA  
17 creates this really strong focus or heightens this  
18 difference, and so when you have asymmetry in terms of the  
19 types of information sources that are actually being input  
20 into that model, then it creates this big problem  
21 essentially.

22           And so while I think I don't disagree with

1 anything that you said that we should try to make fee-for-  
2 service coding more accurate and we don't want to punish MA  
3 for having more accurate coding or anything like that,  
4 there's just this systematic heightening of this  
5 difference, and that that has a big budgetary impact that's  
6 creating a lack of parity.

7           To some extent -- and I'm not supporting this,  
8 but I'm just pointing this out, that if you take the laws  
9 that have been -- or approaches that have been used around  
10 community rating and such that have been more age- and  
11 demographic-based, then it wouldn't actually be  
12 hypothetically crazy to say, well, what if we just use age  
13 and demographic to compensate over an entire group?  
14 Because ultimately, insurance is supporting this insurance  
15 function where there is going to be volatility and risk.

16           So again, I'm not saying that we should have bad  
17 coding or anything like that, but my point is that as a  
18 starting point saying we should have a parity and we should  
19 have comparability across how these budgets are assigned,  
20 it's actually a very good starting place. From there, we  
21 can try to make all the system fixes that you and others  
22 have pointed out to. But it's not crazy in the context of

1 how insurance works in the first place to say that we would  
2 start with demographics plus some perhaps imperfect measure  
3 of risk in some way.

4 DR. CHERNEW: I've lost track a little bit, but I  
5 think Robert wanted to have a Round 3.

6 DR. MILLER: I had an -- on this point after  
7 Amol.

8 DR. CHERNEW: Oh, I'm sorry.

9 DR. MILLER: So I don't think people hear me say  
10 this very often, but I am going to say it, which is that  
11 part of the reason this is interesting to me is it suggests  
12 to me that hospitals are underpaid. Usually, there's an  
13 earthquake when I say something like that.

14 And so thinking -- and I too, Jonathan, have  
15 taught diagnosis coding, and it's hard. Doctors are like  
16 cats. They don't exactly follow directions particularly  
17 well and get off the -- stay off the dining table.

18 I guess this gets to the question of, should we  
19 be thinking about, again, creating parity? I don't think  
20 we'll ever get to 100 percent parity. But should we think  
21 about applying a risk adjustment model to fee-for-service  
22 writ large to help equalize that? Because if fee-for-



1 service is underpaid and MA is overpaid, obviously, there  
2 probably would be then some cut maybe to MA, or should we  
3 increase the payment to fee-for-service and have a similar  
4 risk adjustment methodology for both the MA plan and the  
5 fee-for-service Medicare plan?

6 MS. KELLEY: Robert.

7 DR. CHERRY: So my Round 3 is related to Mike's  
8 comments earlier, and I do agree. I think the reason why  
9 we're talking about this at all is because this is a  
10 payment issue, right? Because, yeah, coding intensity is  
11 the marker here, but as there are more beneficiaries  
12 enrolling in MA, the costs are going up because of our  
13 payment model.

14 I'm just thinking out loud here, but I do wonder  
15 whether or not any potential solutions in the future might  
16 be related to a certain inflection point. In other words,  
17 right now we're at 52 percent MA. When we get to, let's  
18 say, 75 percent MA, the solutions around this issue might,  
19 in fact, be easier, because then we might be thinking fee-  
20 for-service is actually the problem, or maybe a solution  
21 around the payment model may be easier to actually enact  
22 when you get to that certain inflection point.

1           So I'm just throwing that out there because I  
2 agree we're far away from recommendations, but it may be  
3 easier as MA grows to figure what that might be in the  
4 future.

5           MS. KELLEY: Betty.

6           DR. RAMBUR: Thank you.

7           This has been very interesting, and I've been  
8 very quiet in this conversation because I'm taking it all  
9 in. But I just wanted to underscore that I think this is  
10 incredibly important work and as we move to this quadrant  
11 where we can really study it. And I will share that  
12 that's, in part, because I have blood on my hands as a  
13 clinician. I distinctly remember being sat down and taught  
14 how to maximize coding, and I was very disturbed by it.  
15 And I didn't really have the background to understand the  
16 whole piece, right? You know, you're young, and it really  
17 disturbed me. I even at one point left the profession.

18           So I think this is extremely important, extremely  
19 difficult, and we may not be able to do it all. But I do  
20 want to underscore Greg's comment that it's much easier to  
21 think about maximizing coding than doing the hard work at  
22 the surface. So however we think about this, can we make

1 sure that that's our guiding principle, not having extra  
2 costs and waste and doing the hard work at the surface? So  
3 thank you.

4 MS. KELLEY: Larry had a comment. He says: Just  
5 to be clear, we will never have coding in fee-for-service  
6 that accurately includes all diagnoses, because it takes  
7 physician time plus, hypothetically, some kind of organized  
8 information-gathering process by provider organizations.  
9 Both cost money, and none of this money is reimbursed, nor  
10 should it be.

11 DR. CHERNEW: Okay. First, Andy, thank you.

12 For those of you at home, that took -- that's a  
13 long time coming to go through all of this stuff. I think  
14 we originally met with Rick a year ago. We've been having  
15 continual conversations about this aspect of things. I am  
16 going to ask a question again, but I wanted to start by  
17 acknowledging all of the hard work that went behind this.

18 I want to thank all of the Commissioners for  
19 their view. It is clear amongst everybody that there is an  
20 appetite. Everybody's mind goes to, what should we do?  
21 How should we change things. That is a reasonable and  
22 interesting place for people's minds to go. That is a very

1 useful question. There's a series of other policy  
2 questions related to that, like if we were to make a  
3 change, what happens? And there's unintended consequences  
4 in a range of ways, the various things that we have done.

5 I will say in response to something that Kenny  
6 said about there's a new risk model. All numbers might  
7 change. One thing that's clear is, basically, yes,  
8 exactly, that we will over time, as we report back when the  
9 new risk model comes in -- there will be a different  
10 estimate of coding because of the new risk model, and this  
11 method will capture that with the new risk model, and that,  
12 in general, is a good thing.

13 And in fact, one thing that I like about this is  
14 -- you may have not noted -- over the course of those long  
15 graphs where there's coding, risk models are changing as  
16 well in that context, right? And we're kind of smoothing  
17 over and not emphasizing that, oh, these years are V22,  
18 these years are V24, this is going to be V28. This gives  
19 us kind of a window that is temporarily okay or at least  
20 temporarily less of that different risk model kind of  
21 questions as we go through and do this approach.

22 So that's my general sense. There is one core

1 thing that I hadn't heard anyone saying. So I'm just going  
2 to ask Andy to say it, because I think it's useful to say  
3 in the public meeting, which is the central issue here --  
4 and to some extent, it was in the other model, but the  
5 central issue here is that we are relying on outside  
6 estimates of the relative average health of MA and fee-for-  
7 service people in this model. And there is some literature  
8 on that that is important, and that literature, though I  
9 would argue robust, is -- you know, none of that is ever  
10 completely airtight.

11           And so, Andy, if you want to take a second and  
12 talk a little bit about it, because that's the key. That's  
13 the -- if you believe that literature, which I think is  
14 what we're relying on for this, that drives all of this.  
15 And if you don't, then we have to think about where and how  
16 we think that's wrong. So, Andy, if you want to take a  
17 second and speak about it. Do you know what I'm referring  
18 to?

19           DR. JOHNSON: I think you're referring to the  
20 favorable selection or --

21           DR. CHERNEW: Or the sort of assumption that if  
22 you look at mortality and other things, yeah.

1 DR. JOHNSON: Starting with Luis's analysis  
2 published in our July 2023 report, we find favorable  
3 selection to MA, but the principle, as it applies to coding  
4 intensity, is that basically people who have the same risk  
5 score in MA and fee-for-service end up -- the MA enrollees  
6 end up spending less than the fee-for-service  
7 beneficiaries. So there's other research that has used  
8 prescription drug data or mortality, and basically, all of  
9 it shows that after you account for a risk score, the  
10 beneficiaries in MA are no sicker and probably healthier  
11 than the fee-for-service beneficiaries.

12 DR. CHERNEW: And importantly, mortality would be  
13 an example, and mortality is not the same as spending, but  
14 let me just say that's not coming from like plan-reported  
15 data.

16 DR. JOHNSON: Right.

17 DR. CHERNEW: So there's sort of this external  
18 validation that we believe that, in general, the MA  
19 enrollees -- and I cannot emphasize enough -- on average --  
20 that is very -- a lot of other things that matter but, on  
21 average, are, by and large, not sicker once you do these  
22 sort of other adjustments. And the fact that they're

1 appearing sicker on codes, in fact, much sicker on codes,  
2 suggests that something is going on in coding.

3           The last thing I -- it won't be the last thing.  
4 I just say that to give myself more time -- is in response  
5 to one of your questions, Brian, which I think was spot on  
6 -- is a lot of the academic literature that tries to do  
7 this does it with quasi-experimental designs. It uses a  
8 range of methods. That is useful for estimating the  
9 magnitudes, but it's not useful for an ongoing monitoring  
10 exercise. You can't just do that on a regular basis, and  
11 so that's where -- what I think may not be appreciated by  
12 the people listening at home -- is the number of different  
13 triangulation exercises that have gone on to get a sense of  
14 where we are.

15           And we have a number. You'll see the number. I  
16 will tell you, honestly, our recommendation now is that CMS  
17 should cut MA rates by at least 2 percent. I think that's  
18 the basic standing MedPAC recommendation that's most  
19 relevant to this.

20           I don't know if the argument is going to be,  
21 well, it's 13 percent or it's 10 percent or some number,  
22 but I think that it's pretty constant, if you look at all

1 the stuff that will show up in the status report, that the  
2 number is big. And when we think about what to do  
3 holistically about that -- it's much deeper than coding --  
4 I think it's safe to say with rebates at an all-time high,  
5 plans entering as much as they possibly can, that measures  
6 we have of coding, which is not even the selection  
7 measures, which get added on top of this, is that we're  
8 pretty tame in the grand scheme of where our  
9 recommendations are.

10           So while I very much appreciate both this work  
11 and all of the other broader comments of what we can do and  
12 the point if we could get this -- the biggest advantage to  
13 me of getting it out of the hands of clinicians is how much  
14 time and attention and resources are spent trying to have  
15 clinicians maximize coding with consultants and IT systems  
16 and stuff and not actually deliver care. So if we could  
17 find a way just to administratively simplify this issue,  
18 it's important. But it is crucial that we -- independent  
19 of this level issue -- do not discourage health plans from  
20 serving sicker beneficiaries.

21           And there are absolutely some health plans that  
22 specialize -- I'm looking at Scott now. There are some



1 health plans that specialize in serving really frail  
2 people, and it is important that we accurately reward those  
3 plans at the same time as we don't overpay just broadly on  
4 average. And we will continue to do that and try and  
5 manage both the level and the heterogeneity.

6 But that's broadly where at least I am on  
7 thinking through this, and I hope that we will be able to  
8 get through the rest of the discussions with less, what I  
9 consider, distracting debate about whether the number is 13  
10 or 9 or 15 in a range of way, and hopefully, we could think  
11 through simpler, administratively simpler, ways of doing  
12 code.

13 We talk about physician burnout, for example, and  
14 I wish -- Larry, I just wish you were here. But I think  
15 Larry would argue some of these things that physicians are  
16 being forced to do via coding and other things are  
17 contributing to some of our workforce problems easily as  
18 much as a few percentage points on the updates, and so we  
19 would need to think about that seriously, anyway.

20 All right. So I'm going to ask in a moment if  
21 anyone wants to add anything, but before I do, for those of  
22 you at home, we also want to hear your thoughts on this

1 topic or benefit standardization for that matter. So  
2 please reach out to us at MeetingComments@medpac.gov, go to  
3 the website, or otherwise reach out to us to let us know  
4 what you think about this analysis and the conversation  
5 that ensued. We really do want to hear from folks at home.

6 Check and see what anyone has said.

7 All right. So I think we're getting to the end.

8 Paul, do you want to add anything?

9 MR. MASI: No.

10 I do just want to check. Andy, is there anything  
11 you want to get in on, or are you good?

12 DR. JOHNSON: I think a couple of points we  
13 discussed, sort of the future plans for this work, and I  
14 think going forward, we have been thinking that our 2016  
15 recommendation to address for the full effect of coding  
16 intensity still stands, and that is not changing or going  
17 against that. This is just, as an ongoing basis, how do we  
18 track and measure the estimate of coding intensity going  
19 forward, so that doesn't affect that standing  
20 recommendation. But this will be showing up in some of our  
21 future work for tracking this issue.

22 DR. CHERNEW: So again, thanks to those who were

1 listening at home. Thanks to the staff, all of you who  
2 presented and those who have been doing a lot of the other  
3 work. Thank you to the Commissioners. A big thank you to  
4 Paul for his first day in public meeting. So that was all  
5 good.

6 And we'll be back tomorrow morning to talk about  
7 hospital at home and ambulatory surgery centers.

8 So again, thank you, and we are now adjourned.

9 [Whereupon, at 4:55 p.m., the meeting was  
10 recessed, to reconvene on Friday, September 8, 2023, at  
11 9:00 a.m.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
1300 Pennsylvania Avenue, NW  
Washington, D.C. 20004

Friday, September 8, 2023  
9:00 a.m.

COMMISSIONERS PRESENT:

MICHAEL CHERNEW, PhD, Chair  
AMOL S. NAVATHE, MD, PhD, Vice Chair  
LAWRENCE P. CASALINO, MD, PhD  
ROBERT CHERRY, MD, MS, FACS, FACHE  
CHERYL DAMBERG, PhD, MPH  
STACIE B. DUSETZINA, PhD  
JONATHAN B. JAFFERY, MD, MS, MMM, FACP  
KENNY KAN, CPA, CFA, MAAA  
R. TAMARA KONETZKA, PhD  
BRIAN MILLER, MD, MBA, MPH  
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AGENDA	PAGE
Medicare's Acute Care Hospital at Home program	
- Evan Christman.....	3
Recess.....	79
Ambulatory surgical centers: A primer	
- Dan Zabinski.....	79
Adjourn.....	122

P R O C E E D I N G S

[9:00 a.m.]

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DR. CHERNEW: Hi, everybody. Welcome back to our September MedPAC meeting.

We have two really interesting topics today.

Sorry. We were working through an echo.

The first one is a topic that I've had a lot of people ask about -- and I think there's a tremendous interest amongst policymakers and others -- on how policy will address this issue, which is hospital at home.

So I think we've got some great work here. Without further ado, I'm going to guess I'm turning it over to Evan, so, Evan.

MR. CHRISTMAN: Thank you, Mike.

Good morning. Before I begin, I would note that this presentation is available on the control panel on the right-hand side of your screen.

This morning, we will discuss the Medicare Acute Care Hospital at Home program. Today's presentation provides an overview of the program that we plan to include in an upcoming report.

This presentation will have three parts. We will

1 review the development and features of the hospital-at-home  
2 model of care. Next, we will examine the experience of the  
3 fee-for-service Hospital at Home program established during  
4 the public health emergency, and finally, we will turn our  
5 attention to considerations for the future of the program  
6 in Medicare.

7           First, the program I will be discussing is  
8 Medicare's version of a model of care, referred to as  
9 "Hospital at Home," which is a model that provides  
10 inpatient acute care at a beneficiary's home in place of a  
11 stay at a regular hospital.

12           Hospital at Home programs have been operating in  
13 health systems abroad for many years, and experimentation  
14 with them began in the U.S. in the 1990s.

15           Adoption of hospital at home has been relatively  
16 modest in the United States, but during the pandemic,  
17 interest in the model increased due to concerns about  
18 hospital capacity. The concerns led Medicare to establish  
19 a Hospital at Home program and fee-for-service called the  
20 "Acute Care Hospital at Home program," or ACHaH for short.

21           A few general issues about Hospital at Home  
22 programs are worth noting. Hospital at Home is a new care

1 model, and it is still being defined. The programs in fee-  
2 for-service and the literature we will review today varied  
3 in the clinical conditions served and services offered,  
4 reflecting variation in health system needs and the  
5 capacity for in-home care.

6 How beneficiaries are referred to the program can  
7 also vary. The most common form is for patients presenting  
8 at the hospital emergency department to be evaluated and  
9 offered the service as an option. However, some programs  
10 have experimented with referring patients from non-hospital  
11 settings. Hospital at Home programs can also have  
12 different approaches for when in-home services are  
13 initiated.

14 In the early supported discharge model, a  
15 beneficiary has a procedure at the hospital and a shortened  
16 overnight stay in the facility but then is sent home to  
17 receive the balance of their post-procedure acute care.

18 In the admission avoidance model, a patient has  
19 no in- facility stay. For example, a patient with a  
20 serious exacerbation of a chronic condition could be seen  
21 in the emergency department, evaluated as needing inpatient  
22 care to recover, and sent home immediately to begin this



1 care with Hospital at Home services.

2           Hospital at Home programs vary in their design  
3 but have a few common elements. In general, the programs  
4 seek to identify patients that are sick enough to need an  
5 inpatient level of care but are medically stable enough to  
6 be served through intensive clinical services in the home.  
7 So, for example, a hospital operating this model will  
8 establish clinical criteria and other requirements that  
9 define the conditions, services, and other factors that  
10 indicate a patient may be safely served at home.

11           Patients meeting these criteria, generally after  
12 being evaluated at the hospital, will be sent home to  
13 receive their acute services. These services typically  
14 include one to two in-person visits by a nurse daily and  
15 one daily consultation with a doctor.

16           Hospitals provide the full range of services a  
17 beneficiary needs in the home. The services available will  
18 vary based on patient need and hospital capability but  
19 generally include pharmacy, diagnostic services, such as  
20 labs and radiology, food, and in some cases, personal care  
21 services.

22           Hospital at Home programs also establish a

1 geographic area for their operations, and one goal of this  
2 is to ensure that beneficiaries are near the hospital in  
3 the event of a medical emergency.

4           There have been numerous trials of Hospital at  
5 Home in the U.S. and abroad. In this analysis, we do not  
6 conduct an exhaustive review of these trials, but I want to  
7 highlight the conclusions of two systematic reviews of  
8 Hospital at Home trials to provide a general sense of the  
9 results.

10           These two reviews summarize results from 19  
11 trials. Both systematic reviews concluded that mortality  
12 was comparable for Hospital at Home patients and usual care  
13 patients for the trials they reviewed. This may reflect  
14 that patient safety is usually a primary consideration, and  
15 hospitals focus on patients that they believe are safe at  
16 home.

17           For other outcomes, the results varied. For  
18 example, for length of stay, one review noted that Hospital  
19 at Home patients had longer stays than usual care, while  
20 the others did not compute an average across trial, but  
21 noted that some found Hospital at Home patients had shorter  
22 stays, while others had longer stays compared to usual

1 care.

2           The conclusions for readmissions and patient  
3 function also differed, with one study finding fewer  
4 readmissions for Hospital at Home patients, while the  
5 others found no difference.

6           The evidence for Hospital at Home and lowering  
7 costs was very limited. One systematic review found that  
8 most studies did not comprehensively study costs but noted  
9 that two did suggest lower spending.

10           Two trials of Hospital at Home that included  
11 Medicare beneficiaries provide illustrations of the  
12 complexities of running these programs and evaluating their  
13 outcomes. In 2014, Mount Sinai Hospital received a Healthy  
14 Care Innovation Award from CMS to establish a Hospital at  
15 Home program in New York. The program was able to enroll  
16 about 300 patients, but the evaluators noted that startup  
17 was challenging. And the program had to revise its  
18 approach to recruiting patients for the trial and also how  
19 it's staffed for the in-home services.

20           About 49 percent of patients offered the service  
21 accepted it. In this program, the CMS evaluation concluded  
22 that a quantitative evaluation of outcomes was not

1 possible. Beneficiaries were offered the option of  
2 Hospital at Home services after evaluation by the hospital  
3 and were not randomized.

4 Administrative data do not capture many aspects  
5 of severity used to identify Hospital at Home programs. So  
6 a control group could not be identified from hospital  
7 claims or other data. As a result, the evaluation did not  
8 assess the costs or other quantitative outcomes for this  
9 grant.

10 In 2017, Brigham and Women's Hospital conducted a  
11 randomized trial of Hospital at Home. The program focused  
12 on infections, heart failure, hypertension, and atrial  
13 fibrillation. The service was offered to beneficiaries  
14 evaluated in the emergency department. About 37 percent of  
15 beneficiaries offered the benefit accepted, and a total of  
16 91 patients were randomized to the intervention and control  
17 group.

18 The evaluation found that Hospital at Home  
19 patients had shorter stays, lower rates of readmissions,  
20 and lower costs compared to usual care. The study noted  
21 that Hospital at Home patients tended to receive fewer  
22 tests and labs compared to the control group that received

1 regular inpatient care. The Brigham and Women's study has  
2 the advantage of being a randomized study, but the study  
3 size was small.

4           In November 2020, concerns about hospital  
5 capacity during the coronavirus pandemic led CMS to  
6 establish a Hospital at Home program within Medicare fee-  
7 for-service, again, referred to as Acute Care Hospital at  
8 Home, or ACHaH. Under the program, hospitals could apply  
9 for a waiver to deliver the acute inpatient benefit at a  
10 patient's home. Hospitals approved for the program were  
11 responsible for selecting the clinical conditions that  
12 would be treated at home. Under the waiver, hospitals are  
13 responsible for providing all of the services a beneficiary  
14 may need and providing a baseline of clinical services in  
15 the home, including two daily visits, in-person daily  
16 visits by a clinician, a daily consultation with a  
17 physician which may be virtual, a communication system for  
18 the beneficiary to reach the hospital staff for urgent  
19 inquiries, and also requiring that the hospital be able to  
20 dispatch clinical staff to the beneficiary's home within 30  
21 minutes if necessary.

22           Hospitals are also required to report program

1 metrics such as volume, mortality, and the number of  
2 patients who had to be escalated from the home to the  
3 hospital.

4 Payment under the program is the standard amount  
5 as under the inpatient prospective payment system. No  
6 additional payment is made if a patient has to be escalated  
7 from the home to facility-based care.

8 There has been some interest in the program, but  
9 so far the uptake has been relatively modest. As you can  
10 see in the chart on the left, about 285 hospitals have been  
11 approved to operate in the program, but only 101, or 35  
12 percent, reported any volume. About two-thirds of  
13 hospitals had no reported volume. For those 101 active  
14 hospitals, they were more likely to be urban and nonprofit  
15 facilities. In addition, the active hospitals were larger  
16 in size and also had higher occupancy rates. This suggests  
17 that hospitals active in the program were under more  
18 pressure to find additional capacity.

19 Across the 101 active hospitals with at least one  
20 discharge, the 18 hospitals with a hundred or more  
21 discharges accounted for over 60 percent of the volume in  
22 2022. Though it is not shown on this chart, on a monthly

1 basis, volume was increasing during 2022, so the low volume  
2 may reflect that many programs have been in a startup  
3 phase. But overall, these numbers indicate the volume  
4 remains low, and a minority of hospitals with waivers are  
5 active.

6           Looking at the claims data for the program, the  
7 most common primary diagnosis were for infections and  
8 chronic conditions, such as heart failure and COPD. We  
9 compared the length of stay and other attributes for  
10 Hospital at Home discharges to non-Hospital at Home  
11 discharges in the same hospitals for the same DRGs. Our  
12 analysis found that the Hospital at Home length of stay was  
13 nine-tenths of a day longer on average, but the average  
14 allowable charges for some services, such as labs and  
15 radiology, were lower, suggesting that Hospital at Home  
16 patients received fewer of these services compared to  
17 patients served in a facility.

18           These lower charges for some services may at  
19 least, in part, reflect that patients within a DRG who are  
20 referred to Hospital at Home may be less clinically severe.  
21 However, I would note that prior trials have had a similar  
22 finding of lower spending for these services. And of note,

1 the Brigham and Women's study, which randomized patients,  
2 also found lower spending for labs and radiology.

3           This brings us to the current status of ACHaH.  
4 CMS originally established the program under emergency  
5 authority available to it when the PHE was in effect. CMS  
6 has indicated that it does not have the authority to  
7 continue the program after the PHE concluded.

8           As a result, Congress opted to extend the program  
9 through the end of 2024 after the public health emergency  
10 was terminated. Future legislative action will be  
11 necessary to extend the program. The Consolidated  
12 Appropriations Act requires HHS to submit an evaluation  
13 that considers the utilization, quality outcomes, and costs  
14 for the program in the fall of 2024. However, conducting  
15 this analysis will be challenging. The program is small  
16 and being operated as a voluntary service. Beneficiaries  
17 have not been randomized to the program. Past experience  
18 has demonstrated that it is difficult to construct control  
19 groups of usual-care beneficiaries because of the way  
20 Hospital at Home patients are selected and referred to the  
21 program.

22           Secondly, current administrative data do not



1 identify all of the services and costs incurred by  
2 hospitals in this model of care.

3           And finally, there is variation in the types of  
4 patients and services across hospitals, making it difficult  
5 to fully characterize the care being provided across the  
6 program.

7           This brings us to considerations for the future  
8 of the program. Given the short tenure and low volume of  
9 the program, it will be challenging to draw conclusive  
10 observations from the current experience, but there are  
11 some key questions Medicare and the Commission may want to  
12 discuss.

13           First is assessing the value of the Hospital at  
14 Home model. The results for most studies indicate that  
15 beneficiaries can be safely served in the home, but  
16 questions remain about outcomes and cost. Commissioners  
17 may want to address how Medicare should approach the  
18 evaluation challenges for the program. A critical issue is  
19 that patients are selected for the program using detailed  
20 clinical and social data that is not captured in Medicare's  
21 claims.

22           Commissioners may also want to discuss whether

1 there are any specific types of quality measures that  
2 pertain to in-home acute care that might be important to  
3 develop.

4 Another issue is cost. Current studies present  
5 an unclear picture of whether Hospital at Home is lower  
6 cost compared to usual care. It appears that Hospital at  
7 Home patients receive fewer of some services, but these  
8 services can be more costly to provide at home than in  
9 facilities.

10 Do Commissioners have views on how these two  
11 factors balance out? One consistent finding on cost is  
12 that Hospital at Home patients tend to receive fewer labs  
13 and radiology services than usual-care patients, suggesting  
14 overuse during an inpatient stay. What factors might  
15 explain this, and how Medicare might address it?

16 In addition, Hospital at Home is a new and  
17 evolving care model. Hospitals have substantial  
18 flexibility to determine the patients and services included  
19 in the current program. Does Medicare need to take steps  
20 to better define the care model? Examples of issues  
21 Medicare could look at include the substitution of virtual  
22 physician visits for in-person exams beneficiaries

1 typically receive during a hospitalization, assessing  
2 whether programs should or should not require a caregiver  
3 be present in the home, and whether it would be beneficial  
4 to collect more data about the services beneficiaries  
5 receive, such as the amount of practitioner time or the use  
6 of digital monitoring services.

7           This completes my presentation. I look forward  
8 to your discussion.

9           DR. CHERNEW: So, Evan, thank you. This is a  
10 really interesting topic and something that I think we're  
11 going to see a lot more of in a whole range of areas, how  
12 to provide care in different settings.

13           We're going to launch through the queues in a  
14 minute. I just want to say to everybody, right now, this  
15 is most likely going to be a chapter. We're not going to  
16 have recommendations. We're really at the beginning stages  
17 of understanding this work and getting your preferences and  
18 your thoughts on some of the questions like are the studies  
19 generalizable and things that I won't say now are useful.

20           So, anyway, let's start with the queue, and if I  
21 have it correctly, the first person in the cue is Cheryl.

22           DR. DAMBERG: Thank you.

1           Thank you, Evan and Jeff. This was a really  
2 interesting chapter.

3           I'm suspecting you don't know the answer to these  
4 questions, but I thought I would try. So there were quite  
5 a few hospitals that did not actually have any cases or  
6 participate. Was there anything in the studies to suggest  
7 why they're not coming to the table?

8           MR. CHRISTMAN: That's something that has been  
9 talked about in trade press and places like that. I'm not  
10 familiar with any formal study that's done it.

11           I think the three factors that come up -- and  
12 these are in no particular order -- are setting up a new  
13 service line that may involve hiring new staff, and if  
14 people can hire additional nurses and other practitioners,  
15 they often have other openings they want to backfill on  
16 their existing service line. So one is staffing.

17           The other one is people report that the financial  
18 case for this is sometimes difficult to make at the  
19 hospital level, that some hospitals have judged that it  
20 does work, and others, they're perhaps concluding  
21 differently or still having that conversation.

22           And then the other one we hear is uncertainty, if

1 the program is only going to last through 2024, you know,  
2 setting up a new service line. And so if you were to  
3 compare the 101 to the 184, they're probably -- adjudicated  
4 those issues differently would probably be part of it.

5 DR. DAMBERG: Yeah. I mean, it seems like  
6 there's some amount of scale that you have to bring to the  
7 table, given the large percentage in terms of bigger  
8 hospitals.

9 My second quick question was it was a little  
10 unclear to me what defines the end of a stay, and at one  
11 point, does it morph into like home health?

12 MR. CHRISTMAN: So perhaps one way to think about  
13 this is when CMS set up this program, they were setting up  
14 in November of 2020 when there were serious concerns about  
15 the hospital capacity, and they wanted to put in place a  
16 program that let people move as fast as possible. And so  
17 they define and say think of this as a hospital stay, but  
18 you're doing it at home. It's similar in every other  
19 respect.

20 So for example, when the patient is admitted by  
21 whatever leveling criteria you meet, you use, they have to  
22 need an inpatient level of care, and so when they no longer

1 need that inpatient level of care, they are discharged.

2 In contrast to home health, as you may be aware,  
3 there's a skilled need, homebound, those types of things,  
4 and that's how it's being applied.

5 DR. CHERNEW: Can I ask a follow-up around one  
6 question? How vague are those criteria you just mentioned  
7 no longer needing?

8 MR. CHRISTMAN: There are a lot of people at this  
9 table who have applied it professionally.

10 [pause]

11 DR. CHERNEW: So for those at home, Wayne is  
12 saying subjective clinical judgment. Dana is saying please  
13 use the microphone. And Jonathan is saying very vague, as  
14 it is with inpatient in general.

15 MR. CHRISTMAN: Yeah. I guess there's some  
16 studies I looked at that looked at this issue. It's an  
17 entire subgenre of literature of just differences and  
18 admission decisions across physicians, particularly when  
19 they're dealing with an individual who has an exacerbation  
20 of a chronic condition. And I think this is designed to  
21 target a certain type of beneficiary who is not succeeding  
22 with the care they have in the community and needs short-

1 term intensive intervention, and that's certainly one  
2 population of this. So I think there's some variability.

3 One other thing on this point. Another thing  
4 that makes it challenging to compare these is one of the  
5 factors that sometimes limits somebody from being  
6 discharged from the hospital is what support they have at  
7 home, and so that's a factor that obviously is very  
8 different in the situation.

9 DR. CHERNEW: I'm sorry. We got off track on the  
10 Round 1. So was that the end of your Round 1, Cheryl?  
11 Okay. Now we'll be more disciplined and go through the  
12 queue. Dana, who's next?

13 MS. KELLEY: Jaewon.

14 DR. RYU: Yeah. I have two and a half questions.  
15 The first one is, do we have any insight or maybe an  
16 inventory of which states have a permissive environment for  
17 this? Because I think that may hit at Cheryl's first  
18 question. I'm aware that there are some states who through  
19 their departments of health don't allow this, so would love  
20 to hear what we know.

21 MR. CHRISTMAN: Yeah. That's a great question,  
22 and we can look into that. That's been loosely mentioned

1 and is one factor in the literature, but I don't think  
2 anybody -- I'll see if anybody's done any sort of  
3 inventory, but noting the state regulatory environment is  
4 important.

5 DR. RYU: And then the cases that have been  
6 reported, I wonder if the 101 versus the 185 or however  
7 many, do those include -- do the cases for all of those  
8 include programs that are run through payers through MA  
9 programs?

10 MR. CHRISTMAN: No. This is just fee-for-  
11 service.

12 DR. RYU: Okay. And then, as sort of a side  
13 note, I'm guessing they do obviously include the ACOs, but  
14 I think any patterns around -- the ones who are involved in  
15 ACOs, are they more likely to be in that 101 where they're  
16 actually following through and reporting versus the ones  
17 that are not choosing to go through with it?

18 MR. CHRISTMAN: We haven't looked at that, but we  
19 could take a peek at that.

20 MS. KELLEY: Scott.

21 DR. SARRAN: Thanks. Thanks, Evan for getting  
22 some shape and organization to our thinking around this.



1 I'm trying to make sure I'm understanding and we're able to  
2 understand the cost impact. So if I'm thinking about this  
3 right, somebody can come into a Hospital at Home stay  
4 either from home, from ER, from observation, or from  
5 inpatient, and so if we're going to understand the  
6 incremental or differential cost of the Hospital at Home  
7 program versus an inpatient stay, I would think we've got  
8 to tease out the total cost based on which of those  
9 pathways were used.

10 MR. CHRISTMAN: Right.

11 DR. SARRAN: And then the question, if that's  
12 correct, are we able to do that given the data we have?

13 MR. CHRISTMAN: Right. And I would -- I think I  
14 would -- I think you've got it. You sound -- I think the  
15 thing I would amplify is that in the Medicare and the fee-  
16 for-service program, you have to come through the hospital  
17 setting. Other programs outside of fee-for-service have  
18 done it from the community setting or other settings, but  
19 again, the way to think of this program is they took the  
20 inpatient hospital conditions of participation in the way  
21 of two rules. Everything else remains in effect. To CMS,  
22 this is a hospital stay, and they require that a

1 beneficiary go through the hospital, but --

2 DR. SARRAN: After the hospital, could that be ER  
3 only?

4 MR. CHRISTMAN: Yes, yes.

5 DR. SARRAN: So it's still three pathways, right?  
6 ER, obs, or inpatient.

7 MR. CHRISTMAN: Right. And another wrinkle, a  
8 fair point, is that an obs stay wouldn't get picked up in  
9 this because that is an observation stay, and you got to  
10 meet that hospital leveling criteria. We sort of hear  
11 about two -- I think there's two general on-ramps, and one  
12 is the ED evaluation. And I think there are a handful of  
13 people who may be doing the so-called "early supported  
14 discharge" for somebody who just needs a certain procedure.  
15 And that's one of the frustrations is it might be possible  
16 to figure out what approach they're doing from  
17 administrative data. But it's not reported now. So I  
18 can't tell you here's the ESD cases and here's the hospital  
19 avoidance cases.

20 DR. SARRAN: I know this is more a quick Round 2  
21 comment, but I think it's just important that we capture in  
22 our chapter the need to understand the differential costs

1 of those different on-ramps into a Hospital at Home stay.

2 MS. KELLEY: Brian.

3 DR. MILLER: I have more Round 2 comments, but I  
4 do have a few Round 1 comments, which are I really love  
5 this chapter. And it was balanced and thoughtful. This is  
6 not an easy chapter, not an easy topic. It's not easy to  
7 parse these studies. I think one of the things that I also  
8 really liked is there was a strong emphasis on the  
9 importance of non-physician providers and technology,  
10 because none of these models will work without that.

11 And just selfishly, we're getting close to my  
12 dream of Star Trek-level medical care where you can get  
13 health care wherever you want when you need it.

14 Thank you.

15 MS. KELLEY: Amol.

16 DR. NAVATHE: Thanks, Even, for this great work.

17 I also add some other comments in Round 2, but I  
18 had four questions. The first actually is just to follow  
19 up to Jaewon's around the state regulatory environments. I  
20 was curious, what are the differences? Is that primarily  
21 labor workforce-related requirements, or what are the  
22 different aspects of regulatory policy that vary for states

1 that might just --

2 MR. CHRISTMAN: I'm not in a really good position  
3 to answer that. I guess I just get the sense that there  
4 are state regulations that intended to protect the hospital  
5 level of care that make it harder to do it at home where  
6 they -- but I'm not too deep on that, and we can look  
7 deeper into that.

8 DR. NAVATHE: Great. Okay. Okay.

9 So my other questions, one, I was just curious.  
10 These Hospital at Home admissions, do they get represented  
11 in Medicare claims the same way as other hospitalizations,  
12 or do they look different in some way? How are you able to  
13 identify them?

14 MR. CHRISTMAN: I'm going to try my best here,  
15 but my colleague has worked with the claims. And I guess  
16 I'll just say that starting in -- I think it was 2022.  
17 They started requiring specific information to flag that it  
18 was a Hospital at Home claim. Now, remember, the program  
19 started in 2021. CMS has been tracking volume through a  
20 separate -- basically a hospital sending in monthly rosters  
21 through sort of a spreadsheet-based system. So the answer  
22 is, going forward, I think we'll have a little more

1 information on the claim.

2           It's been a little ad hoc, but they are -- they  
3 should show up in the IPPS claims because, again,  
4 administratively, this is just another hospital claim.  
5 It's done in a different site of service, but from  
6 Medicare's perspective, they get the standard DRG with  
7 whatever adjusters apply. And so there will be a claim  
8 going forward. We should be able to identify those claims,  
9 but that's been a limitation that they -- they weren't  
10 required to report the stuff when it started up.

11           DR. NAVATHE: I see. Thank you.

12           Next question I had is -- so you noted that there  
13 was -- and this is kind of somewhat related to Cheryl's  
14 questions and other questions, but you noted in the  
15 analysis that there was an increase in length of stay, and  
16 I think you said nine-tenths of a day on average. And I  
17 was curious. Although I know there are requirements to  
18 your points about needing an inpatient level of care and  
19 such, I was curious to what extent that increased length of  
20 stay may have offset home health agency care. Were you  
21 able to observe any of that in the data that you looked at?

22           MR. CHRISTMAN: No. And we can look at that. I

1 think the -- we're treating the claims information as  
2 useful, but as I -- they weren't required to report this on  
3 claims until the middle of 2022, I think. And the rosters  
4 that they have submitted have some holes. So how far we  
5 could push that without snapping it, I guess, but we can  
6 take a look at that.

7 DR. NAVATHE: Great. Okay.

8 And then my last question is maybe a bit of a  
9 leading one in a sense. So my understanding is, based on  
10 the reading, that this was created really to allow for  
11 flexibilities, particularly in the context of the pandemic  
12 and otherwise. In most of the home care, remote care,  
13 technology-based stuff, to use a very technical term, there  
14 is a general sense that capital infrastructure is  
15 different, and so maybe in the longer -- maybe not in the  
16 short run, but maybe in the long run, this should generate  
17 savings for the Medicare program or something like that.

18 Has there been any discussion of that in any of  
19 the CMS regs or anything that allow this, or has it  
20 completely stayed away from any sort of anticipatory  
21 effects or approach that might be coming in the future?

22 DR. STENSLAND: Yeah. I think the capital isn't

1 that much. The capital costs of a hospital just aren't  
2 there much, maybe 10 percent, and so, you know, it's so  
3 much of a labor-driven thing. And then when you have your  
4 Hospital at Home, you have some different capital you need.  
5 They have their command center, usually, where everything  
6 is going out of, and then they have their capital to move  
7 things back and forth. Sometimes then they contract out  
8 with mobile imaging services. So there's this other group  
9 of capital that you're creating when you do a Hospital at  
10 Home, and the amount of capital you're eliminating is not  
11 that great. So I would say that effect is going to be  
12 small relative to the labor effect.

13 DR. NAVATHE: I see. So that totally makes sense  
14 to me, and so I think, I guess that what I'm hearing from  
15 you is because of that rationale, there's not really been  
16 any articulation that this is the way per se to save the  
17 program money in the long run but rather to allow the  
18 flexibility for innovation for patients, et cetera.

19 Okay. Thank you.

20 MR. MASI: Can I try to add one point on this?  
21 It may be worth separating apart cost to the provider and  
22 cost to the program where -- I agree with everything Jeff

1 said with respect to capital, but the extent to which this  
2 changes cost for the provider over some period of time, the  
3 program would realize or not those changes, if there are  
4 payment changes made to how Medicare pays. And I think I  
5 just wanted to tease apart that concept as well.

6 DR. NAVATHE: I guess the other thing that I  
7 think -- at least I've envisioned this -- is that in a very  
8 long game setting -- and the one other piece, I guess,  
9 Jeff, you didn't mention directly, remote patient  
10 monitoring. And so there's a bunch of, again, probably --  
11 it doesn't change the thrust of what your comments were,  
12 but in the very long-range planning, if Hospital at Home or  
13 other home-based care takes up a significant amount of the  
14 ecosystem, then there are fewer -- there's a need for fewer  
15 brick and mortar beds in the long run, and that might alter  
16 cost structures and potentially payment structures down the  
17 road. But that's going to take a while.

18 MS. KELLEY: Okay. I have Gina.

19 MS. UPCHURCH: Yeah, just quickly. And I can't  
20 remember. I think it was from this chapter. Caregiver and  
21 patient experience. Can you talk a little bit about that?  
22 And then how is the pharmacy benefit -- if it's Part A,



1 obviously, pharmacy benefits included in Part A, just if  
2 you talk about that.

3 Thanks.

4 MR. CHRISTMAN: Sure. I'll take the pharmacy bit  
5 first. In all of these services and pharmacies -- this  
6 applies to all the ancillary services -- basically, the  
7 hospital has to come up with a way to deliver in a timely  
8 manner to the patient's house. So the nurse comes in, in  
9 the morning, and takes vitals and decides something needs -  
10 - works with the doctor, decides something needs to be  
11 adjusted, that the hospital under this benefit is under the  
12 hook as if that beneficiary was in there. Wait. They've  
13 got to get the new med there to them that afternoon. They  
14 don't go to the pharmacy. They don't -- it's delivered for  
15 them.

16 MS. UPCHURCH: Including IV, if somebody needs an  
17 IV.

18 MR. CHRISTMAN: Including what?

19 MS. UPCHURCH: IV, intravenous versus oral.

20 MR. CHRISTMAN: Oh, yes. Yes, right. IV.

21 And that again gets to the abilities of specific  
22 hospitals. Some, if you needed an IV, they'd say we're

1 just not going to do it, and others might be we would do  
2 it. And some might have a cut line of saying there's some  
3 we'll do it at home and some we won't. But yes, that's on  
4 the table. They could do it under the program if they  
5 decided.

6           And then you asked about caregiver, and the --  
7 again, the CMS provided flexibility to hospitals, and this  
8 issue primarily is implicated when they set criteria for  
9 who they're going to admit to the program. And I guess I  
10 would just pull back and say that that means that when  
11 they're evaluating someone, they can say, okay, here's  
12 their -- you know, they have the condition and their proper  
13 sort of pocket of severity, and then the hospital can set  
14 standards and say we're just not going to send -- it's up  
15 to the hospital's discretion. We're going to draw a line  
16 and say if you don't have a caregiver, we just don't feel  
17 comfortable doing this at all. They could say we'll go for  
18 it.

19           And there's also flexibility around how much  
20 personal care services they provide. They could just say  
21 we don't do that at all, and some programs will say I'll  
22 send someone there 24 hours a day.

1 MS. UPCHURCH: And what is the patient -- do we  
2 know about patient experience and caregiver experience of  
3 having this in the home?

4 MR. CHRISTMAN: Okay. So the -- let's see if I  
5 can sum up on this correctly. When they've done patient  
6 experience surveys, kind of like a mini-CAHPS or something  
7 for beneficiaries, I think it's been -- in general, I think  
8 it's either been equal or better. It varies a little bit  
9 across, and remember this is a voluntary service. These  
10 are people who volunteered for it.

11 The caregiver piece, I can't recover right now.  
12 I think that's been less studied, but I don't have much  
13 more on that.

14 MS. KELLEY: Okay. I have some Round 1 questions  
15 from Larry. Larry says that he likes this program very  
16 much. His first question is, is there a risk that  
17 hospitals will admit people to a Hospital at Home that they  
18 would not normally admit to inpatient care? And are there  
19 currently any safeguards against this?

20 MR. CHRISTMAN: I would say that there are the  
21 same safeguards for a patient that has admitted to the  
22 bricks and mortar facility. The programs will have their

1 standards for who they admit. Sort of the linchpin of this  
2 is that it's supposed to be an equal benefit, equal  
3 severity to, and, you know, I think that the -- so I think  
4 it's sort of the traditional volume and fee-for-service  
5 question. And yeah, I think that is a concern, but I think  
6 it's sort of the same challenges as addressing it for  
7 bricks and mortar facility services.

8 DR. STENSLAND: I would just add, if people  
9 remember a few years ago, there was a lot of controversy  
10 with the RACs, were challenging the medical necessity of  
11 admissions into the hospital, and people were not getting  
12 paid. And then there was a lot of discussion with CMS.  
13 Well, how can we define this better so we know whether they  
14 should be in the hospital or not? And then they ended up  
15 with a two-day length-of-stay rule saying if they think  
16 they have to be in their two days, well, then we'll call  
17 that "medical necessity." But I think that whole process  
18 was an example of how difficult that it is to get consensus  
19 around some particular criteria to determine if someone  
20 needs to be in the hospital.

21 DR. CHERNEW: And as an aside, I think the  
22 geographic variation literature and other literature

1 suggests that whatever you think the criteria is, it's not  
2 always being applied the same way in the same places.

3 MS. KELLEY: Okay. Larry asked about the five  
4 and a half days longer length of stay that was found in one  
5 review. He wonders: Is that right?

6 [Laughter.]

7 MR. CHRISTMAN: Well, I hope it is. I believe it  
8 is. I think to keep in mind, part of the challenge of  
9 looking at the literature for Hospital at Home is a lot of  
10 these systems have been operated overseas and are in other  
11 health systems. And so my understanding is the very notion  
12 of what is provided on an inpatient basis can be very  
13 different. That five and a half days might be against a  
14 health system that functions very differently than what  
15 we're accustomed to.

16 We included that work just to give people a  
17 general sense of what's out there and what these programs  
18 look like, but that's part of the challenge of using the  
19 international comparisons. They can show us interesting  
20 things but some question as to how well they might apply to  
21 our circumstances.

22 MS. KELLEY: Okay. And on page 21, Larry asks

1 when considering cost to caregivers, it would be good to  
2 also consider the cost to caregivers when their loved ones  
3 are hospitalized, the traveling to and being at the  
4 hospital and the time and psychological costs of trying to  
5 be there when clinicians visit the patient and often  
6 missing them.

7 He also wondered if -- was there any discussion  
8 anywhere in the literature of not requiring two in-person  
9 visits?

10 MR. CHRISTMAN: So this is definitely one that  
11 comes up often, and yes, in the Medicare program, I think  
12 it's kind of envisioned almost as like a morning visit and  
13 an afternoon visit. And I think there is a sense that for  
14 some patients, that may not be necessary. But right now,  
15 that's Medicare's standard, and I think they intended that  
16 as this was a new program, and that was a safeguard to  
17 ensure minimum baseline of service.

18 MS. KELLEY: So Larry says for many patients, one  
19 probably would be plenty, in his opinion, and it would be  
20 easy to use more virtual visits per day for patients who  
21 need them.

22 And then his final request is that it might be

1 useful to explain to us how Brigham randomized its  
2 patients.

3 MR. CHRISTMAN: We can look into that. I almost  
4 always want to say you read too many of these studies, and  
5 some of those -- I'm sure it was block, but I won't swear  
6 to that. And in the process of doing this study I -- or  
7 doing this work, I actually read a study that complained  
8 about journal articles not always adequately explaining  
9 their randomization. We can look into that, but I assume  
10 it was some form of block.

11 DR. NAVATHE: On this point, Evan, do you have a  
12 sense? Are they randomizing after people articulate their  
13 willingness to participate?

14 MR. CHRISTMAN: Yes.

15 DR. NAVATHE: They are. Yeah, okay.

16 MS. KELLEY: I think that's all we have for Round  
17 1, unless I've missed anyone.

18 DR. CHERNEW: That's what I had too, and so we  
19 can jump into Round 2, and I think, Jonathan, you are going  
20 to kick us off.

21 DR. JAFFERY: Thanks, Mike.

22 So, Evan and Jeff, this is great. I'm super

1 excited about this chapter. People who've been here for a  
2 while know I've been a big advocate for home-based care  
3 broadly for at least my entire time on the Commission, so  
4 really excited about the work, really excited about the  
5 program.

6           And I'll start off with a few comments related to  
7 things that have come up in the Round 1 discussion. So you  
8 had mentioned actually at some point that -- why people are  
9 -- we were talking about why organizations have chosen to  
10 do this or not to do this and related to some capacity  
11 issues that came up during COVID. And I would just say  
12 that there are a lot of our hospitals and health systems  
13 out there that continue to have significant capacity  
14 issues.

15           And I know during our December discussion, we  
16 often talk about the capacity being adequate at 65 percent,  
17 but that's a national number. And so we know that, in  
18 fact, there are places that are 75, 85, 95, even over 100  
19 percent, well above the comfort level of adequately running  
20 a facility.

21           You mentioned the reluctance that that places  
22 might have had because of the uncertainty about the



1 program, and I think that that can't be overstated. That's  
2 absolutely the case. And why some places may have chosen  
3 to over others is -- and it has to do probably with other  
4 payers. So there are some commercial payers that have been  
5 in the space because people were doing this before the  
6 pandemic, and particularly if you own your own health plan,  
7 Jaewon and Greg may have comments about that, but that  
8 might make it -- whether that's through MA or commercial  
9 may make it more likely that somebody does.

10 I have a couple comments just about things within  
11 the chapter, and then I'll finish up by trying to address  
12 some of the questions that you have on the final slide.

13 So this is just in order of how they appear, and  
14 some are pretty minor, and some are more substantive. But  
15 you talk about the initial -- in the second sentence on  
16 page 1 and I think some other places throughout, many years  
17 that hospitals and payers have experimented with this, and  
18 I would just -- I wouldn't use the word "hospitals" there.  
19 I would really talk about providers because it's really a  
20 larger ecosystem than just the hospitals.

21 Talking about the length of stay, just building  
22 on what others have said, stays don't necessarily equal

1 stays here.

2           And Cheryl's question right up front was  
3 important. I think basically you've got the supervised  
4 glide path to an independent home, and I had the same  
5 question that Amol asked about home health. So I think  
6 that's a really important thing to look at if we can and  
7 just recognize that they're not exactly the same.

8           On page 4, you list some issues to consider, and  
9 one thing I didn't see emphasized in the chapter that might  
10 be is the potential for increased patient safety in the  
11 home. So concerns, maybe fewer concerns about falls, and  
12 these get into some things that maybe we want to look at.  
13 Iatrogenic infections, confusion, some of those things at  
14 least potentially could be better if people are in their  
15 home environment.

16           And then, finally, just a comment before I get to  
17 your discussion questions, about the Brigham and Women's  
18 trial. Definitely, there was a lot of attention paid to  
19 that, I think, when programs were launching, and so, you  
20 know, for better or worse, I think there probably were a  
21 number of people -- I saw this at least in some examples or  
22 some instances where they were modeling things after that

1 based on the fact that this was at least one, not very big,  
2 but it wasn't just a case study. It was sort of the best  
3 thing out there.

4 In terms of the questions and some of the quality  
5 measures, I think I would start with our principles of  
6 using a limited set of population-based measures that are  
7 driven towards outcomes. I think that trying to get  
8 caregiver and patient experience is important, and there's  
9 comments. We should be getting those things, especially,  
10 particularly what Larry said. We should be getting that --  
11 those for inpatient, people in brick and mortar stays. The  
12 caregiver experience and the caregiver impact is not  
13 insignificant for people, and so we should consider that.

14 And at the end of the day, I think, obviously, we  
15 should align these with the inpatient measures as much as  
16 possible so that we can actually compare things.

17 In terms of some of the costs and in terms of  
18 less testing, I think that was a really intriguing  
19 observation. Some things to me seem pretty clear that  
20 there are less barriers to getting another lab test or  
21 another imaging test in the hospital. It's pretty simple  
22 as opposed to sending your contracted imaging folks out or

1 doing it when the nurse is visiting.

2           There also may be a bias if you've got -- if  
3 people are being -- having those inpatient stays. We're  
4 comparing it to places where there are residents. That's a  
5 big factor, and we have a whole IME payment that, you know,  
6 tense, you know, is purposeful about dealing with some of  
7 that. I think this happens less and less, but my physician  
8 colleagues will recall writing orders for standing daily  
9 labs. Then at some point, people got us to stop doing, or  
10 we told people to stop doing, but that was -- that's what  
11 you did. So that was kind of the culture.

12           And then, finally, in terms of some of the things  
13 about virtual visits, I think this -- it's important to try  
14 and leverage that.

15           In terms of the physicians, may consider an  
16 initial in-person visit and maybe something periodic, but I  
17 think I think that that would be -- I think we should  
18 leverage that.

19           And then in terms of some of the data that we get  
20 for tracking, I guess the one thing I would urge us is to  
21 try and make that uniform. One of the things I see as  
22 problematic in lots of different environments is that I

1 think agencies, not just CMS but agencies across the board  
2 in an attempt to create flexibility for people and not be  
3 too prescriptive sometimes are too open. I think community  
4 benefits is a great example. That wasn't CMS, but they --  
5 those are -- the community benefits tracking is often very  
6 qualitative and narrative. And I would say that I would  
7 hope that was an attempt to be flexible, but it actually  
8 makes it more difficult, I think, for organizations to  
9 report things at some point, and then the data, of course,  
10 is less helpful for policymakers.

11           So again, fantastic chapter. I'm super excited  
12 about this work, and thanks so much.

13           MS. KELLEY: Tamara.

14           DR. KONETZKA: I was really, really pleased to  
15 see an extensive discussion of the caregiver issues at the  
16 end of this chapter. As somebody who studied caregiving  
17 and also a caregiver myself, I feel like it's something we  
18 too often ignore or just become sort of a one-line caveat  
19 at the end of a paper.

20           I think there's so much momentum across the  
21 health care system, not just this program, toward home-  
22 based care, and I'm glad to see that it's come up already

1 so many times this morning and that it was in the chapter.  
2 But I think too often, we don't really consider those costs  
3 and benefits, partly due to data limitations.

4           We have a paper under review, for example, that  
5 looks at caregiver burden under bundled payments for lower  
6 extremity joint replacement, and we find that because that  
7 program sort of incited people to get home health care  
8 rather than institutional or SNF care, that caregiver  
9 burden actually increased. And people's functional  
10 impairment is higher when they get discharged from home  
11 health. So these effects are real, and it's going to be a  
12 factor every time we think about home-based care models.

13           So I guess I would say two things. One, I'll  
14 echo other people's suggestions that as this program is  
15 extended and other evaluations are undertaken, that we  
16 really insist to the extent we can on ongoing evaluations  
17 of caregiver burden, caregiver costs and benefits, whether  
18 they accept the at-home option or whether they go to the  
19 hospital. I'd also love to see if they reject the at-home  
20 option, is that about the caregiver role or not or if  
21 that's possible to collect as well.

22           And I think that the fact that it's voluntary

1 doesn't really change things that much. We know there's  
2 incredible costs to caregiving. I'm, for example,  
3 ostensibly a voluntary caregiver, and that doesn't mean  
4 it's not a huge burden and doesn't involve costs in a  
5 variety of ways.

6           So yeah, collect more data. We know we can't do  
7 this after the fact with claims. So any ongoing  
8 evaluations, it's really essential that we get that primary  
9 data collection.

10           And the other thing I would say is in everything  
11 we consider, way beyond this program, any kind of program  
12 that encourages care at home, directly or indirectly, I  
13 would hope that we, as a group, continue to sort of push  
14 for more data and thinking more about the effect, indirect  
15 effects on caregivers.

16           MS. KELLEY: Stacie.

17           DR. DUSETZINA: Thank you.

18           This was a really excellent chapter, and I  
19 enjoyed reading it very much as someone who's learned a  
20 little bit about Hospital at Home through my own  
21 organization.

22           I have a couple. I want to plus-one a lot of

1 Jonathan's comments on measurement and thinking about the  
2 population-based outcomes, and also, to Jonathan and  
3 Tamara's comments around caregiver experience, I definitely  
4 think caregiver and patient experience in this program  
5 definitely seem important to measure.

6           You know, I'm reading this and thinking about  
7 evaluators and how they're going to have to deal with this.  
8 You could teach a class on selection bias for this. I  
9 mean, it's like spot on, exactly the problem that they're  
10 dealing with, and I didn't know if there was any  
11 possibility at all -- this is probably a dream -- of having  
12 CMS incentivize some of these sites that are doing this to  
13 start to do block randomization.

14           Actually, as they're having people enter, try to  
15 actually put some structure on it, especially if there are  
16 capacity constraints. I get that that would be kind of a  
17 voluntary thing for the sites to do, but to be able to know  
18 if anyone is doing it, because some of these sites are  
19 academic medical centers. And there are people who are  
20 researching Hospital at Home and want to do that in a  
21 rigorous way. So maybe there's a possibility of like  
22 partnership there, because it just feels almost impossible



1 to get over the selection issues.

2           Even just thinking about, you know, if I were  
3 being evaluated, hospital or go Hospital at Home, I think  
4 the look on my physician's face would even tell me whether  
5 I should say yes, I would be willing to be randomized or  
6 not. You know, it's this level of comfort that I think  
7 could be influenced by so much. So even in the  
8 randomization, it's going to be tough, because there could  
9 still be those other kind of subtle nudges. And the issue  
10 of caregiver support and people who can help you at home is  
11 a big one.

12           And another thing just for the evaluation is you  
13 guys did a great job talking about the variability and the  
14 participation and the scale issues that have been described  
15 in the literature, and it feels like you definitely want to  
16 stratify analyses by larger programs and smaller programs  
17 where those -- at least acknowledging the fact that  
18 hospitals might get a lot better at this over time with  
19 experience or they'll figure out the staffing issues that  
20 are maybe making it a bumpy start. So I think that that's  
21 going to be really important for at least figuring out how  
22 things are going.

1           But this is really great work, and I think it's  
2 exciting to see how this is working out for beneficiaries.

3           DR. CHERNEW: Stacie, I want to ask a question  
4 about your selection point. There's two types of  
5 selection. I want to make sure I understand which one  
6 you're talking about.

7           There's within an institution, who's getting  
8 Hospital at Home or not, and although that's an important  
9 selection issue, maybe that's fine because we want to just  
10 evaluate whoever would endogenously select into it. Then  
11 there's selection about which institutions are actually  
12 doing Hospital at Home or not.

13          DR. DUSETZINA: Yeah.

14          DR. CHERNEW: And so I'm interested in each of  
15 those selection issues.

16          DR. DUSETZINA: I'm worried about both, partly  
17 because I think there are infrastructure issues that have  
18 been pointed out in the chapter around who can do this  
19 well, and sometimes with highly specialized services, you  
20 see -- or even if you thought about something like  
21 surgeries, like more experience is often better for  
22 outcomes. So you want to think about the apples-to-apples

1 comparison as much as you can around who's participating,  
2 and maybe volume of who's in the program could give you  
3 some sense of like more comparable across institutions.

4 But I think the selection within the patient  
5 population, like who's willing to do it or not -- and even  
6 which physicians are willing to send their patients to  
7 Hospital at Home, you could maybe even think about it from  
8 that perspective because maybe there's a little bit more  
9 caution for individual clinicians like referring.

10 DR. NAVATHE: Can I follow up right there?

11 Sorry.

12 So are you worried about more from a  
13 methodological, are we really understanding what's  
14 happening at Hospital at Home perspective, or are you  
15 worried about it more from the perspective -- especially  
16 when you start to talk about the hospital level, but it  
17 could be within hospital as well, the sort of equity of  
18 access. Is it -- are we more likely to end up with certain  
19 populations being offered Hospital at Home because of the  
20 social supports they need at home, or at least perceptions  
21 around social support?

22 DR. DUSETZINA: Yeah.

1 DR. NAVATHE: And could that lead to very unequal  
2 access to --

3 DR. DUSETZINA: Yeah, very much both of those  
4 things.

5 DR. NAVATHE: Both. Okay.

6 DR. DUSETZINA: And I think that that's one  
7 reason you want to make sure that you understand how well  
8 this works from a randomized perspective, if you could,  
9 because I think the selection bias makes it so that you're  
10 leaning towards -- you know, the people who are selected  
11 for Hospital at Home are probably going to kind of have  
12 better outcomes because there's this kind of sense that  
13 they'll do better, right? That's at least the way I would  
14 think of the directionality of the potential bias when  
15 you're not randomizing people.

16 But I think there's also the issue of, you know,  
17 like if this is a program that is something that  
18 beneficiaries and their families would like to be able to  
19 participate in, you want to make sure that where the sites  
20 of care that are participating have enough scale so that's  
21 not a negative experience or not such a differential  
22 experience across different sites. And I think that could

1 very much vary by hospital resources and the communities  
2 that they serve more broadly.

3 MS. KELLEY: Betty.

4 DR. RAMBUR: Thank you so much. I will pile on  
5 my enthusiasm, and I'll try to just amplify a few points.

6 To me, one of the most exciting things about this  
7 is that instead of requiring patients and families to adapt  
8 to the hospital culture, we're requiring providers really  
9 to adapt to the culture of the family and the community,  
10 and this is really a big deal. That should not be  
11 underestimated.

12 And as I think about the potential, it seems to  
13 me there will be a lot more potential for better post-acute  
14 care after the Hospital at Home part, because you  
15 understand the family, the conditions, the resources.

16 And that said, I want to pile on Stacie's about  
17 equity of access, and of course, I'm shaded a bit by my  
18 experience of working as a traditional home health nurse in  
19 a very, very tough, tough neighborhood in Chicago in grad  
20 school. And so the people who most needed home care, it  
21 was easy to not go there, and I was part of a group who  
22 did. And it's really a big deal, so I think we really want

1 to be attentive to that issue.

2 I wanted to also just point out something that's  
3 sort of interesting and puzzling to me. The two visits a  
4 day, one being able to be by a paramedic or a nurse, those  
5 are remarkably different skill sets. If you think about a  
6 paramedic, they are medical care in acute emergencies,  
7 which is very different than, of course, the kind of thing  
8 I would think about a nurse who could do some of that but  
9 who's also thinking about the traditional cycle of social  
10 spiritual, right? That's the thing, and that's really  
11 within the context of the family home and the culture. So  
12 I think that's an interesting thing. What's the real team  
13 configuration that might be needed for different patient  
14 populations?

15 And then my final question is, you know, because  
16 I think I just don't get the whole quality measurement  
17 here, I really support the pieces that have been mentioned  
18 so far around caregiver experience, et cetera. But I  
19 thought that hospital home had to have the same  
20 requirements as traditional inpatient, but the readings  
21 would suggest that they aren't measured on the traditional  
22 hospital value-based purchasing kind of measures. Are

1 those just not -- are those just excluded?

2 MR. CHRISTMAN: I believe they would be treated  
3 normally. I believe they -- I don't think they are  
4 excluded on purpose. I think -- I believe they're part of  
5 -- I'm not familiar with the measures, but I don't -- I  
6 would expect them to be treated as any other inpatient  
7 facility-based case.

8 I think the challenge is, you know, even for the  
9 largest programs, they're doing 100 cases a year. So, per  
10 se, if you wanted to look just at Hospital at Home, you'd  
11 have a very small sample across a range of diagnoses. So  
12 for doing things like caps or things, you start to get to  
13 those issues for looking at specific hospitals.

14 DR. RAMBUR: Because things like communication  
15 with nurses and physicians are in there, et cetera.

16 So thank you very much. Great work, and I'm very  
17 excited to see it evolve.

18 MS. KELLEY: Brian.

19 DR. MILLER: So first of all, plus-one on  
20 comments on beneficiary and caregiver experience being  
21 important, which Tamara and Gina and Betty have mentioned.

22 Also, plus-one on Stacie's comments on equity and

1 equality of access. It's extremely important.

2           So I'm going to have some, I guess I would say,  
3 programmatic criticisms and then opportunities. I wish I'd  
4 heard more from the hospital industry about this program  
5 because I think it's really important. So I'd say  
6 concerns.

7           First, there's the question of cost. We have  
8 taxpaying and non-taxpaying hospitals. Did taxpaying  
9 hospitals participate? I didn't see them mentioned, and  
10 they're highly focused on what is most operationally  
11 efficient and cost -- I see heads shaking no.

12           DR. STENSLAND: There's a much small -- some are,  
13 but there's a much smaller share of the for-profit  
14 hospitals or taxpaying hospitals, as you say, that are  
15 participating.

16           DR. MILLER: So they're often in the Southeast  
17 and some in urban areas, some in rural and underserved  
18 areas, and they're more efficient because they have to pay  
19 taxes.

20           So the fact that they weren't -- or at least a  
21 smaller share were participating suggests that there might  
22 not be as much operational cost savings in this model, and



1 that's something we should consider adding.

2 I had a concern, I guess I would say, about  
3 safety. I know that there wasn't a suggestion of increased  
4 mortality. Thirty minutes is a long time. If you are  
5 decompensating -- I'm a hospitalist, so I practice in a  
6 hospital. I can walk down the hall, and your blood  
7 pressure drops. You stop breathe -- have difficulty  
8 breathing. You need NAB. I can go talk to the nurse. You  
9 need to go to the ICU. We can walk down the hall and  
10 address that. You can't do that at home.

11 And if that beneficiary is at home, they  
12 decompensate, you know, the answer is probably going to be  
13 faster to call EMS than it will be to call the hospital.  
14 And so that's a serious, I would say, safety concern with a  
15 program like this, which, of course, then gets to the  
16 selection criteria. So plus-one on Stacie on selection.

17 So looking at it, we said cognitive impairment,  
18 non-home-based services, frequently not getting IV meds,  
19 not getting imaging. Who's left? Are we paying for  
20 patients that don't even really need to be hospitalized  
21 that are getting admitted to the hospital anyway because  
22 it's easier than sending them home from the ER? And so are

1 we then sending those patients home and paying for  
2 hospital-level care and potentially wasting large sums of  
3 money for the Medicare program?

4           Another concern is, is this going to worsen  
5 health disparities? You mentioned all those patients who  
6 can't get it and the importance of the caregiver. If  
7 you're old and poor and minority in an urban area, how well  
8 and how likely are you going to be served by a program like  
9 this? Because it's dependent upon having that social  
10 support network. It's dependent upon being able to get  
11 access to additional resources.

12           So, in some way, the program as structured seems  
13 very unfair to safety net hospitals, which are serving a  
14 challenging population who don't have a lot of resources.  
15 It seems really unfair to rural hospitals and not  
16 necessarily a lot of economic resources, huge distance to  
17 provide service.

18           I'm thinking, if I'm a CoP or a 150-bed rural  
19 hospital, how can you participate? I did an intern here in  
20 Cooperstown, New York, a village with one stoplight, and  
21 there was a hill surrounding it and a lake. Sometimes in  
22 the winter, you couldn't get over the hill because there

1 was that much snow. So how do you do Hospital at Home and  
2 have a visit when there's a blizzard and a small mountain?

3           Despite this, I think there's something good  
4 here. My question is, is there a level of care between  
5 inpatient care and intensive outpatient care? There's  
6 something there. Could that be observation care? I think  
7 technology and non-clinician -- or non-physician providers  
8 can be huge here.

9           I also see an opportunity for what the telecom  
10 community calls the Internet of Things for health care,  
11 connected devices. My thought is it would be good -- and  
12 may not have the time -- to go talk with FDA and the Center  
13 for Devices and Radiological Health about sort of the tech  
14 that's emerging in this space. Talk with the staff at the  
15 FCC who do health care, and then talk with some of the  
16 device and health tech entrepreneurs sort of about what  
17 they see as the technological potential here, because  
18 there's something here. I'm not sure Hospital at Home is  
19 the answer, but there's definitely a level of care there.  
20 And I think we can all agree that having the beneficiary at  
21 home is better than being in the hospital, because nobody  
22 wants to be in the hospital.

1 Thank you.

2 MS. KELLEY: Amol.

3 DR. NAVATHE: Thanks, Evan and Jeff. This is  
4 really fantastic work. I think you've done a really  
5 wonderful job of synthesizing what's out there in the  
6 literature but then also on not only supplementing it with  
7 additional analyses in the MedPAC way but also, I think,  
8 highlighting what we can take away from the literature and  
9 also what we can't take away from the literature, which is,  
10 as we've heard from a lot of Commissioners, I think,  
11 equally as important here in the context of where we are in  
12 the kind of growth of a Hospital at Home, an important  
13 area, obviously, but an early area from an evidentiary  
14 perspective. So thank you so much for your very thoughtful  
15 chapter here.

16 So I think this is -- I'm really excited that  
17 we've done something about this at the Commission. I think  
18 it's an important area. Obviously, because of the pandemic  
19 and such, I think we got a huge shove in the direction as a  
20 national system towards trying to develop more flexibility  
21 of caring in the home, and the Medicare program obviously  
22 has done that. And we've commented on that in the context

1 of telehealth, but this is an important part of it. And I  
2 think there's already -- you know, outside of the Medicare  
3 program, there's been at least -- not systematic, but at  
4 least an ad hoc shift in this way.

5           And I agree with Jonathan's comment that it's  
6 very likely that some of the adoption variation that we see  
7 here has not to do with Medicare. per se, but with what's  
8 happening in the other environment that these hospitals are  
9 in and what other investments they've made since it would  
10 be very challenging from a financial perspective to just do  
11 this for a small number of patients.

12           But nonetheless, I think a very important area,  
13 and I think we're going to see evolution in this area  
14 towards a variety of types of home-based care, and I think  
15 it's important that we have started to take on Hospital at  
16 Home. So thank you so much for pushing us in that  
17 direction.

18           I won't say a lot of the comments I actually had  
19 because I think many of the Commissioners have already  
20 mentioned them.

21           A couple of things that I would echo, slash,  
22 maybe add a little bit to supplement, let's call it, that

1 there's obviously a lot of challenges here. There's  
2 opportunity and challenges. One of the things that strikes  
3 me is in our chapter, we highlight that it would be helpful  
4 to have more randomized trials or maybe randomized trials  
5 with Medicare beneficiaries, et cetera.

6 I think it's important -- and I think you all  
7 know this, but I think it might be worth saying is that not  
8 all RCTs are created equal. And we comment on that in the  
9 systematic reviews as well, and so as we were to evolve our  
10 thinking on this, it might actually be helpful for us to  
11 outline what would that RCT -- what are some essential  
12 components of that RCT. Some of that might touch on  
13 Stacie's points around selection. It might touch on  
14 Tamara's points around caregiving. I think trying to  
15 really understand what we're trying to measure -- and  
16 that's why I was asking earlier in the Round 1 around do we  
17 have a sense of what the stated goals are for this from the  
18 program perspective and perhaps from the beneficiary  
19 perspective?

20 I could imagine a world where all the objective -  
21 - quote/unquote, objective outcomes that we observe in  
22 claims and other types of data are very equal. But we see

1 that from a preference perspective or from a caregiving  
2 perspective, it's considered a home run, in which case we  
3 might really want to go in that direction, or it could be  
4 the opposite. And so I think it would be helpful for us,  
5 as we mature our thinking around this, to just understand  
6 what it is that we're valuing here and what the -- and  
7 therefore what we would want to measure and what an RCT  
8 might actually require beyond just needing an RCT in a  
9 sense.

10 I worry a lot about the sort of equity-like  
11 effects or access-type issues that Stacie was including in  
12 her concerns. So I will just reflect very, very quickly.  
13 Like Brian, I'm a hospitalist. I take care of patients who  
14 are admitted to the hospital. I practice within a VA  
15 facility, which has a very robust Hospital at Home program,  
16 and the VA does in general. We take care of a very  
17 underserved population who on average does not have a lot  
18 of social supports, and while I'll spare you the details of  
19 many aspects of how the program works, I would say that my  
20 learnings from the VA broader experience and my own  
21 personal clinical experience is that it certainly has a  
22 role. There are patients who really, really benefit from

1 it and have strong preferences to be able to avail of that  
2 program.

3           There are other patients who elect for preference  
4 reasons or otherwise not to be a part of that program. So I  
5 think that there is clear value here. I think one of the  
6 hardest parts, of course, that's been highlighted -- and  
7 I'll just kind of double down on this point -- is that the  
8 quality measurement parts are challenging because you just  
9 don't have the natural infrastructure of what's happening  
10 in the hospital. So I think, again, kind of tying that  
11 back to the RCT point, it's just helpful for us to make our  
12 thinking a little more sophisticated, and to the extent  
13 that we could articulate it around what are the different  
14 areas that we really need more information around to  
15 understand what's happening?

16           But again, I would just say from my own clinical  
17 and practice experience that there are certainly  
18 operational challenges, but there are ways that this can be  
19 implemented at scale that are really good for patients, and  
20 there's a strong trend towards trying to understand how we  
21 can do more for patients in the home. So I think it's  
22 really important that we've taken this on.



1 Thank you so much.

2 MS. KELLEY: Cheryl.

3 DR. DAMBERG: Again, thank you for this great  
4 work.

5 I'm not going to repeat the comments from my  
6 fellow Commissioners. I agree with all the things that  
7 they've articulated should be measured. I guess the one  
8 thing that I would say is, you know, maybe building a  
9 little bit off of Brian's comments, this is an interesting  
10 innovation. We don't exactly know what it is yet. I think  
11 we would hope we could continue to learn from this  
12 experiment.

13 And the private sector typically goes about this  
14 process through iterative learning, and I think there's an  
15 opportunity, as I would hope we could provide some type of  
16 evaluation framework, to maybe provide some guideposts for  
17 anybody who's working in this space, whether it's CMS or  
18 the private sector, around what we would want measured.

19 And I think the near-term opportunity is around  
20 some qualitative data work. So I don't think it just needs  
21 to be focused on quantitative metrics -- and to really  
22 start understanding what kinds of things need to be put in

1 place to make this work. Is this contributing to  
2 efficiency gains from an organizational standpoint, or is  
3 it kind of a drain on the system in some way that we're not  
4 capturing in some of these quantitative metrics?

5 In particular, Amol, I'd be kind of curious what  
6 the VA's experience is. Does this add additional  
7 complexity to the provider workforce that's already under  
8 siege with provider burnout? I think there's -- we could  
9 be a little more expansive in our thinking about what we  
10 want to measure in this space.

11 MS. KELLEY: Scott.

12 DR. SARRAN: Yeah. I just want to briefly make -  
13 - highlight the concern that I could easily see the patient  
14 safety events markedly increase as the program disseminates  
15 from what at the beginning has been largely well-resourced  
16 hospitals, human resources and programmatic resources, and  
17 the concern is that if this disseminates rapidly to  
18 hospitals who lack some of those capabilities, it's very  
19 easy to see the safety profile worsen. And that in turn  
20 would then create the potential that we pull back on the  
21 whole thing and lose the forward-moving innovation. So I'd  
22 like to see us highlight that issue.

1           I'm not concerned about hospitals already doing  
2 this, expanding the program to a larger cohort of patients,  
3 as much as I am seeing potentially hospitals feeling  
4 pressured into doing this because their competitors are  
5 doing this or, even worse, payers are pushing them to do  
6 this, and yet they're taking it on, lacking the full  
7 infrastructure to make it succeed safely.

8           MS. KELLEY: Jonathan.

9           DR. JAFFERY: Just having gone through the  
10 process of getting CMS approval for the waiver in my old  
11 job, it's pretty darn rigorous. It was multiple, multiple  
12 conversations to really ensure that it, as Evan pointed out  
13 a couple times, this is essentially hospital-level care, by  
14 all criteria, just not in the hospital.

15          DR. SARRAN: I think that's great. I think that  
16 the importance would be not to -- for CMS not to drop that  
17 level of rigor on the front end.

18          DR. MILLER: If I may, the clinical response  
19 time, which I think Scott and I are talking about, is  
20 particularly important for a patient who decompensates.  
21 And so as the program broadens, you'll get a wider range of  
22 patients and then that de-compensation could happen, and

1 there's not a person there to address it, like they are in  
2 the hospital. It's not an acute care need; it's an  
3 emergent need, the emergent being within minutes,

4 MS. KELLEY: Jaewon.

5 DR. RYU: Yeah. Like many others, I really  
6 enjoyed the chapter and I think feel strongly that this is  
7 an important area for us to continue to evaluate, add  
8 information to better understand, and continue to support.  
9 I think it's an important and great option to add to the  
10 continuum of care offerings that are out there.

11 That being said, there's still this two-thirds.  
12 I was a little taken by the Brigham study that had two-  
13 thirds of the folks declining. I knew that there would be  
14 some component, but that's pretty substantial majority,  
15 especially in light of the fact that at least as the  
16 programs have been so far, it looks like the early returns  
17 are pretty promising. So I think getting the information  
18 out there and better understanding to help people feel more  
19 comfortable, I think, is an important part of the work.

20 Also, fully acknowledge that it's not for all  
21 scenarios and, in fact, maybe best left for very targeted  
22 scenarios.

1           And I think this gets to the safety issues that  
2 Scott and Brian and others have mentioned. I think that  
3 exclusion criteria is really important, and the  
4 capabilities in the home and the discussions around the  
5 caregiver, this really has to be the right sweet-spot  
6 environment for this kind of program to flourish.

7           My second point revolves around the logistics and  
8 the infrastructure. I think there's a lot more than meets  
9 the eye just from my own experience on this, and it doesn't  
10 surprise me that the VA, to Amol's point, does this well.  
11 I think places that have been in population payment kind of  
12 environments, they probably have a head start with some of  
13 the building blocks in adjacent capabilities, getting  
14 aspects of the care into the home, which is why I think it  
15 would be interesting to take a look at that 101 and see how  
16 many of them are really either in ACO environments or if we  
17 have line of sight on what's going on in the payer space  
18 with MA and so forth. I think that's where you'll find  
19 synergistic programs that maybe remove some of the barrier  
20 for entry for a program like this.

21           I think it also works the other way around, the  
22 flip side, where -- and this is one of the reasons I'm most

1 excited about the program. Helping programs like this, I  
2 think, add and can catalyze the right building blocks to  
3 hasten uptake around population-based payment models,  
4 whether it's ACO or otherwise. So I think there's a lot  
5 there that it would be great to unearth as we're continuing  
6 to evaluate.

7           Lastly, I want to get back to Larry's point,  
8 because the soft admits, you know, this notion of the  
9 admissions that may not have happened, granted, they all  
10 meet criteria. So I think that's -- Evan, your comment is  
11 spot on. I think it makes sense, but that is one that I  
12 think we have to keep an eye on and maybe continue to  
13 evaluate as we see this program continue to progress.

14           MS. KELLEY: I have a comment from Greg, and he  
15 says: great summary. He says that this will come as no  
16 surprise to those of you who know him, but he believes that  
17 Hospital at Home is best implemented in a capitated  
18 environment, specifically where the provider organization  
19 is capitated.

20           In his experience, the definitional boundaries  
21 between hospital care, Hospital at Home, and home care can  
22 be difficult to establish and is a major challenge when

1 payment is involved, as this excellent chapter describes.

2           However, in a capitated world, it is much easier  
3 to identify patients who can be treated safely in a home  
4 setting and who would benefit socially or clinically by  
5 such treatment. For instance, his organization has found  
6 that rural residents often benefit by being treated at  
7 home, which may seem counterintuitive, since inpatient care  
8 would often remove them from support structures to a  
9 greater degree than those who live closer to hospitals.

10           In the capitated environment, he has found that  
11 they are able to apply higher levels of care to,  
12 quote/unquote, "home care patients" to avoid expensive  
13 hospitalization. This would be problematic if they needed  
14 to justify inpatient care.

15           Evan described how difficult these boundaries are  
16 to establish. It can all be dramatically streamlined in a  
17 prepaid environment.

18           And I have Robert next.

19           DR. CHERRY: Well, thank you. This is a great  
20 chapter and also a great topic for discussion for this  
21 group too.

22           I would say, anecdotally and also based on

1 circumstantial evidence too, I think a lot of these  
2 facilities that are doing this work are doing it with some  
3 degree of success, which is really highly encouraging.

4 I think we also have to keep in mind that there  
5 is a self-selection process. These organizations are  
6 highly reputable and highly capable of executing on  
7 something like this.

8 Nevertheless, with that being said, I think we  
9 need to be grounded that this is still an experimental  
10 model, and although I do favor this continuing, I don't  
11 think it should be continued indefinitely. In other words,  
12 something like this probably should be extended three to  
13 five years so we can get additional experience and evidence  
14 and really understand how it works.

15 There's a lot of things that do need evidence-  
16 based clarifications, and I'll mention a few. What are the  
17 optimal admitting DRGs for safe management for these  
18 patients? I think the inclusion and exclusion criteria  
19 that's been mentioned by several Commissioners also needs  
20 to be formalized and also needs to be evidence-based. The  
21 staffing model is unclear. Are the virtual visits really  
22 just as efficacious as in-person visits? And what does the



1 team-based model look like, particularly around clinical  
2 support services like physical therapy, respiratory  
3 therapy, nutrition, and case management?

4           The escalation procedures for clinical  
5 deterioration, I agree, 30 minutes is a long time, so you  
6 have to be very careful about the patients that are really  
7 eligible for this.

8           I've had longstanding concerns about pharmacy,  
9 delivery, and administration in this particular setting,  
10 including protections against drug diversion and wasting of  
11 narcotics in this particular setting.

12           The standards for remote monitoring, I think, are  
13 also unclear as well as infection prevention practices,  
14 falls prevention, and the rapid response procedures.

15           Although there's inpatient guidance on all these  
16 things that I've mentioned, I think for the home setting,  
17 there's not good regulatory guidance just yet, and so more  
18 evidence is really needed to help, I think, shape those  
19 standards.

20           The hospitals that are doing this, I think, are  
21 highly motivated, and I think they're motivated for a  
22 number of reasons. They're probably having access issues

1 already and need some decompression.

2           There's a need for capacity management and  
3 sufficient patient flow in their facilities, because if  
4 you're not getting the patient to the right place at the  
5 right time with the right team, bad things start to happen,  
6 and it becomes a safety issue, and it also becomes a  
7 patient and family experience issue.

8           The cost avoidance is unclear, and it may not be  
9 the primary motivation.

10           There also could be revenue enhancements by doing  
11 this, because if you're moving lower-acuity patients out to  
12 the home environment, you may be backfilling them with  
13 higher acuity patients with a higher margin, but that would  
14 really need to be studied.

15           It's interesting that this is done through a fee-  
16 for-service model. It would be fascinating to see, as  
17 others have mentioned, how this might work under an MA  
18 model as well.

19           I do have some preliminary concerns. The payment  
20 is the same, but probably, the resource intensity and  
21 acuity is not, for reasons that have been mentioned  
22 already.

1           It is extremely difficult to, I think, get a  
2 program like this off the ground operationally and  
3 sustained over a long period of time, which is why only 35  
4 percent of those hospitals are able to pull it off. Plus,  
5 there's a very narrow spectrum of willing patients that are  
6 eligible to do this as well.

7           It also has to be done in the right house or home  
8 setting. So you have to pay attention to what are the  
9 bathrooms like, are there steps involved, what's the  
10 internet access for virtual visits, and it may, in fact,  
11 include certain patients, particularly in disadvantaged  
12 communities, which has been mentioned before by Brian.

13           I'm also concerned that for patient selection and  
14 improper training or at least education of the caregiver  
15 that there's a shift of some services that providers  
16 normally do to the caregiver that they may not necessarily  
17 be prepared for.

18           Now, I don't want to seem like a total naysayer  
19 on this, because I actually do favor exploring this really  
20 much further, but I think it should be done under a  
21 demonstration project under CMMI, because then you're able  
22 to pull the leaders together, get their collective

1 experience, which helps to shape standards. The  
2 administrative data is going to be lacking, but under a  
3 demonstration project, you're able to pull other types of  
4 prospective data like adverse event reporting, which can  
5 help shape the regulatory standards of the future.

6           So I think it's fascinating. I think that this  
7 is probably the future in terms of where health care is  
8 going for those patients that need a Hospital at Home  
9 environment. It's just that it needs to be studied. So  
10 some of the answers to the questions that we have can be  
11 clarified.

12           So thank you. Really great work on this topic.

13           MS. KELLEY: Okay. I have a comment from Kenny.  
14 Kenny says that he is very enthusiastic about the work. He  
15 vividly recalls some anecdotes and stories from a few  
16 fellow Commissioners about hospitals, especially rural and  
17 safety net hospitals, serving a public good in the  
18 communities that they serve while having to adapt their  
19 cost structure in a future value-based care ecosystem.

20           As there is increased secular momentum towards  
21 home-based care, he believes that hospitals have a role to  
22 play, including ascertaining which services could be

1 performed at home safely and innovatively.

2           Consequently, he suggests that CMS should explore  
3 steps to extend and incentivize Hospital at Home with a  
4 gradual sunset timeline with incremental risk-adjusted  
5 payment changes, better quality measures, and the last  
6 three bullets noted on page 13 of the paper.

7           I also have a comment from Larry that he  
8 completely agrees that more attention should be given to  
9 caregiver costs and experience. He wants to emphasize that  
10 for this particular program, which is an acute care  
11 admission, not long-term care, it's important to balance  
12 the costs and experience of caregivers when their loved  
13 ones are hospitalized in a facility, which can be very  
14 high, versus the cost and experience of caring for a  
15 patient in a Hospital at Home admission.

16           And I think our last Round 2 comment is from  
17 Gina.

18           MS. UPCHURCH: Thank you. And these will be  
19 quick.

20           Just building on Betty's comment about the  
21 culture of being in the home, we talk about ancillary  
22 services in this work, and I'm thinking that's PT/OT. I'm

1 wondering if there's some long-term consequences of having  
2 a physical therapist, occupational therapist in the home,  
3 seeing where you need grab bars. If those things are  
4 actually implemented, it has long-term complications beyond  
5 the admission to the Hospital at Home. So I just think  
6 there's some real positivity that can come from those  
7 ancillary services being in the home, especially also as we  
8 have health systems that are supposed to be pivoting to  
9 social drivers of health, which has not been their thing,  
10 to actually be in the home and have that experience as  
11 being affiliated with the health system and seeing what's  
12 going on in the community and connecting with those  
13 community resources potentially. So I think there's some  
14 potential added benefit there. They're exposed, and  
15 they're learning about what's happening in the homes a  
16 little bit more.

17           And then the second thing I would just ask -- or  
18 comment on is why are -- the caregivers that are declining  
19 or the individuals who are declining, is that a lot about  
20 caregiver burnout, or what do we know there? Because I can  
21 imagine, if you have someone with cognitive impairment and  
22 you're thinking, oh, they've got to go to the hospital, I

1 can get two days rest potentially -- I mean, there's -- it  
2 goes either way, so I think we just need to know more about  
3 that -- and just very supportive of this moving forward.

4 Thank you so much.

5 DR. CHERNEW: Okay. We're at time, and I want to  
6 make sure we have time to do the ASC work that's coming  
7 next. So I'm going to try and summarize very briefly a few  
8 broad points.

9 First, there's widespread support, I think, for  
10 the concept of providing care at home, if we can do so  
11 safely, and there's recognition that it helps a lot of  
12 people. We want to do it and if we were in the VA, for  
13 example. So I feel that support.

14 There's a number of concerns -- I won't go  
15 through them -- about caregivers, costs, implementation,  
16 and a bunch of things like that.

17 I will just say two things personally. One is  
18 right now; we're just going to sort of report this. We  
19 don't have a policy in mind, so this has been unbelievably  
20 useful in thinking through those issues. I worry about  
21 that criteria for who enters when they enter, for who exits  
22 when they exit.

1           The other thing, though, that I worry in  
2 particular about in these evaluations is sort of the  
3 generalizability and what we mean. I think we go back and  
4 forth about does it work. Do you mean the marginal patient  
5 who could have been in that wasn't? Is that the right  
6 comparison? That's a different question than what if we  
7 took hospitals that want to do it and said, "No, you  
8 can't." That's a separate research question with a  
9 separate -- you can't get that by randomizing within a  
10 hospital, for example.

11           Then there's another question. What if we  
12 encouraged hospitals that so far have not wanted to do it  
13 to do it? That's a different question because the answer  
14 is going to depend on the nature of the institution. The  
15 context is going to matter, and all of those answers are  
16 going to depend crucially on the tools that we wrap around  
17 this. Who's eligible? How do we pay? What are the  
18 quality measures? So there's not going to be a unique  
19 answer.

20           We often talk about the question: Does Hospital  
21 at Home work? But it turns out the counterfactual to that  
22 and who's at the margin -- and it's a local treatment



1 effect or an average treatment effect -- turns out to be --  
2 I will never say it again -- turns out to be really  
3 challenging in how we do this.

4           What I take from this is despite the widespread  
5 support for this in concept, there's a lot of concern --  
6 and I apologize for this phrase -- for releasing it into  
7 the wild, as if it's just a regular inpatient stay with the  
8 same payments and stuff, because of all of these other  
9 various issues.

10           So I think both, there is a lot to be learned,  
11 but we have to understand that the answer is not going to  
12 be a uniform answer. It's going to depend on a bunch of  
13 other things, and we're going to be way down the path.

14           So I think many people came up, in a managed  
15 setting, the VA, capitation, MA, good quality measures, we  
16 might be much more comfortable than a broad "It seems to  
17 work here. Let's let everybody do it."

18           So I'm going to leave it at that. We will  
19 continue to discuss this. This has been a really rich  
20 discussion, and I think we're going to take, because of  
21 time -- we're a minute over the start time of the next, but  
22 we are still going to take a break. We're going to take

1 like a three-minute break. It is going to be quick.  
2 That's a two sodas on the chair -- in kind of comment, and  
3 so come back quickly, and we're going to switch to  
4 ambulatory surgery centers. Thank you.

5 [Recess.]

6 DR. CHERNEW: Okay, everybody. We're running a  
7 little behind, so we're going to have to be cognizant of  
8 that as we move. That does not reflect anything on this  
9 issue, which is one that we have dealt with for a long time  
10 and will continue to deal with, and this is something that  
11 we incorporate into our materials as the ASC status report.

12 So I'm going to turn it over to Dan to talk about  
13 ambulatory surgical centers. Dan.

14 DR. ZABINSKI: All right. Thanks Mike.

15 So today we'll provide an informative  
16 presentation about ambulatory surgical centers, or ASCs.  
17 The purpose of ASCs is narrow because they strictly provide  
18 outpatient surgical procedures that don't require an  
19 overnight stay.

20 Medicare coverage of ASCs began in 1982 under  
21 Medicare Part B, and before 2008, the ASC payment system  
22 covered over 2,500 services but had only nine payment

1 categories. And as a result, each payment category had  
2 many services.

3           Moreover, all the services in the same payment  
4 category had the same payment rate. So it was likely that  
5 some services were overpaid while others were underpaid.

6           Then in 2008, CMS implemented a completely new  
7 ASC payment system, which satisfied a requirement in the  
8 Medicare Modernization Act of 2003. Under this new system,  
9 CMS substantially increased the number of covered services.  
10 Most were surgical procedures, but some were imaging  
11 services, which was new. Other items that were covered  
12 under this updated payment system included brachytherapy  
13 sources, passthrough and non-passthrough drugs that were  
14 separately payable under the Outpatient Prospective Payment  
15 System, the OPPS, which is the payment system for most  
16 services provided in hospital outpatient departments, or  
17 HOPDs. Then finally, CMS added medical devices with  
18 passthrough status under the OPPS to the new ASC payment  
19 system.

20           And as is the case for other Medicare prospective  
21 payment systems, payment rates in the ASC payment system  
22 are the product of a relative weight, which is an index

1 that indicates the resources that are needed to furnish a  
2 service, and a conversion factor, which transforms that  
3 relative weight into a dollar figure.

4           What's unique about the ASC system is that the  
5 relative weights for most services are from another payment  
6 system, the OPPS. However, the ASC conversion factor is  
7 lower than the OPPS conversion factor.

8           But one exception to this use of the OPPS  
9 relative weights in the ASC system are office-based  
10 procedures, which are procedures in which the volume in a  
11 physician's office is greater than the volume in ASCs. For  
12 these procedures, the ASC payment rate is the lesser of the  
13 standard ASC payment rate or the non-facility practice  
14 expense from the physician fee schedule.

15           And even though the ASC system is heavily  
16 dependent upon the OPPS, an issue that's causing a growing  
17 disparity between the ASC system and the OPPS is  
18 comprehensive APCs or C-APCs, which applies to an  
19 increasing number of complex services covered under the  
20 OPPS.

21           The idea of a C-APC is that all the items on the  
22 same claim are combined into a single payment unit, even

1 services that would otherwise be separately paid if they  
2 weren't on a C-APC claim. And according to CMS, the  
3 structure of the ASC billing system prevents the use of C-  
4 APCs in the ASC system.

5 In addition, the C-APCs are becoming more  
6 prevalent in the OPPS. From 2016 to 2021, the number of C-  
7 APCs increased from 39 to 79, and the OPPS spending on C-  
8 APCs rose from \$14.2 billion to \$26.5 billion.

9 So because C-APCs are becoming more prevalent in  
10 the OPPS and they can't be used in the ASC system, there's  
11 a growing disparity between the ASC system and the OPPS.

12 An important characteristic of ASCs is that they  
13 focus on a narrow set of surgical procedures. Even though  
14 the ASC system covers more than 3,600 surgical procedures,  
15 only 57 procedures comprise 75 percent of ASC's Medicare  
16 revenue. The highest revenue procedures in ASCs include  
17 cataract removal, GI procedures such as colonoscopies,  
18 neural stimulator insertion, pain management, and knee and  
19 hip replacement.

20 I'll note that the revenue from knee and hip  
21 replacement have been rising quickly. Also, industry  
22 stakeholders are predicting that cardiology services will

1 be increasing rapidly over the next few years, and this is  
2 reflected in the fact that the number of ASCs that  
3 specialize in cardiology rose from 13 in 2016 to 118 in  
4 2021.

5           One thing that's been consistent about ASCs over  
6 time is that volume, the number of facilities, and revenue  
7 have grown steadily. However, the volume growth has been  
8 modest, and the number of ASCs and ASC operating rooms have  
9 grown moderately.

10           In contrast, the growth in Medicare revenue has  
11 been robust. This robust growth largely reflects the  
12 increased complexity of services provided in ASCs,  
13 especially for procedures such as neurostimulator  
14 insertion, knee replacement, and hip replacement. And if  
15 ASCs increase their provision of cardiology services, as  
16 predicted by industry stakeholders, this trend in revenue  
17 growth should continue.

18           An issue regarding ASCs that we frequently  
19 address in the Commission's payment update work is that  
20 ASCs are the only health care facilities that don't submit  
21 Medicare cost data. One of the main arguments for not  
22 submitting the cost data is that it would be overly

1 burdensome on ASCs because they're small facilities.  
2 However, other small facilities such as rural health  
3 clinics, home health agencies, and hospices all submit cost  
4 data, and submission of cost data is important. Without  
5 it, the Commission can't make fully informed assessments of  
6 payment adequacy for ASCs. CMS can't create payment rates  
7 that accurately reflect the relative cost of services in  
8 ASCs, and CMS can't create an ASC market basket that could  
9 be used to update ASC payment rates.

10           The Commission has long been concerned about ASCs  
11 not submitting cost data and has frequently recommended  
12 that the Secretary should require ASCs to submit it.

13           A point about ASCs that we have often made in our  
14 update chapters for ASCs is that a shift of surgical  
15 procedures from HOPDs to ASCs could be beneficial to  
16 Medicare beneficiaries and providers. For Medicare and for  
17 taxpayers, payment rates for the same procedures are lower  
18 in ASCs than in HOPDs, which is a setting that's most  
19 similar to ASCs.

20           For beneficiaries, ASCs offer lower cost-sharing  
21 obligations relative to HOPDs. In addition, due to greater  
22 efficiency, the amount of non-operative time is lower in

1 ASCs than in HOPDs, where non-operative time is the amount  
2 of time a patient is in an operating room minus the time  
3 for the procedure itself.

4 We caution, however, that the lower Medicare  
5 spending and beneficiary cost sharing could be partially  
6 offset if the shift of procedures from HOPDs to ASCs  
7 results in an increased volume of the procedures.

8 For providers, ASCs offer customized surgical  
9 environments, specialized staff, which allows surgeons to  
10 perform more procedures in the same amount of time compared  
11 with HOPDs. Also, physician owners of ASCs can receive a  
12 share of the ASC facility payments.

13 And opportunities do exist for surgical  
14 procedures to shift from the HOPD setting to the ASCs. For  
15 example, we identify the 20 highest-volume procedures in  
16 ASCs, and despite these procedures having high volume in  
17 ASCs, they also have high volume in HOPDs, as HOPD volume  
18 is 79 percent of the ASC volume for those procedures.

19 So these frequently provided ASC procedures offer  
20 an opportunity to shift from HOPDs to ASCs, and we have  
21 found that procedures are shifting from HOPDs to ASCs, but  
22 the shift has been slow. For example, among the 30



1 highest-volume ASC procedures in 2016, the cumulative  
2 growth in volume from 2016 to 2021 was 1.5 percent in ASCs  
3 and a negative 3.4 percent in HOPDs.

4           And we have identified five factors that could be  
5 limiting the shift of procedures from HOPDs to ASCs. One  
6 is that ASCs have little presence in rural areas.

7           Also, ASCs have little presence in areas that  
8 have high social risk factors.

9           Third, some states have restrictive certificate  
10 of need laws that reduce the expansion of ASCs to those  
11 states.

12           Fourth, as we've already mentioned, ASCs provide  
13 a narrow range of surgical procedures while HOPDs provide a  
14 more diverse set of procedures.

15           And fifth, more physicians are becoming hospital  
16 employees rather than working in independent practices, and  
17 we'll cover these five factors over the next six slides.

18           First, we know that 93 percent of ASCs are in  
19 urban counties, while only 7 percent are in rural counties.  
20 On this table, we show the relationship between the  
21 ruralness of counties and ASC concentration.

22           In the first column, we've collected counties by

1 rural-urban continuum code, or RUCC. The idea is that a  
2 higher RUCC value indicates a county is more rural. That  
3 is, RUCC equal to one indicates the most urban counties,  
4 and RUCC equal to 9 equals the most rural counties.

5           In the second column, we have the number of ASCs  
6 per 100,000 residents for each value of RUCC, and you  
7 notice that the number of ASCs per 100,000 residents tends  
8 to decline as the value of RUCC increases. In particular,  
9 there's a clear drop-off in the number of ASCs per capita  
10 for RUCC values 1 through 5 versus RUCC values 6 through 9,  
11 which are the most rural counties.

12           On this slide, we show that the number of ASCs  
13 per Part B Medicare beneficiary decreases as measures of  
14 social risk increase. Note that because of issues in the  
15 underlying data, we use ASCs per Part B beneficiary rather  
16 than per residents, which we did on the previous slide.

17           In this chart, we use the area deprivation index,  
18 the ADI, as a measure for social risk. The ADI uses  
19 income, unemployment, education, and housing quality to  
20 measure social risk in each zip code. The ADI values range  
21 from 1, indicating the lowest social risk, to 100,  
22 indicating highest social risk.

1           In the left column, we collected zip codes into  
2 deciles of ADI measures.

3           In the right column, we have the number of ASCs  
4 per 100,000 Part B beneficiaries for each ADI decile, and  
5 as you can see, the number of ASCs per 100,000 Part B  
6 beneficiaries steadily declines as decile of ADI increases,  
7 indicating lower ASC concentration as social risk  
8 increases.

9           A third factor that could be softening the shift  
10 of procedures from HOPDs to ASCs is that ASCs provide a  
11 narrower range of procedures than do HOPDs. For example,  
12 for ASCs and HOPDs, we determine how many surgical  
13 procedures comprise 75 percent of all their surgical  
14 procedures. For ASCs, 29 surgical procedures comprise 75  
15 percent of their total, but for HOPDs, it's 134 surgical  
16 procedures comprise 75 percent of their total.

17           Drive for efficiency is probably the main reason  
18 for this relatively narrow focus of ASCs, but we also  
19 speculate that payment rate inaccuracies could be  
20 contributing to the narrow focus of ASCs.

21           As we mentioned earlier, ASC payment rates are  
22 largely based on OPPS payment rates, which are derived from

1 HOPD costs, and it's unlikely that the HOPD costs  
2 accurately reflect ASC costs. Hence, it's likely that ASCs  
3 are relatively overpaid for some procedures and underpaid  
4 for others, which can lead ASCs to focus on those  
5 procedures that are most profitable.

6           One change that could help surgical procedures to  
7 shift from HOPDs to ASCs is to increase the number of ASCs  
8 in some states. On this chart, we display the number of  
9 ASCs per 100,000 residents per states at the minimum 25th  
10 percentile, median 75th percentile, and maximum. You can  
11 see that the number of ASCs per capita is very different  
12 among these five states.

13           In particular, the number of ASCs per capita is  
14 18 times higher in Maryland, which is the maximum, compared  
15 with Vermont, which is the minimum.

16           The most likely reason for differences in ASC  
17 concentration among states is differences in certificate of  
18 need, or CON laws. In particular, the nine states with the  
19 lowest number of ASCs per capita all have CON laws.

20           It's also true, however, that CON laws vary in  
21 their degree of restrictiveness. For example, Nevada has a  
22 relatively less restrictive CON law because it applies only

1 to ASCs located in rural areas, and Nevada has the ninth  
2 highest number of ASCs per capita among all states.

3 In addition to CON laws, the share of residents  
4 who are rural dwelling also appears to affect ASC  
5 concentration among states. For example, New Mexico does  
6 not have a CON law, but it does have a high share of rural  
7 dwelling residents. It also has the tenth lowest number of  
8 ASCs per capita among states.

9 And a final point about ASC concentration among  
10 states is that Maryland is unique. It has the most ASCs  
11 per capita by far, but it also has a CON law, and the  
12 likely explanation for this high concentration of ASCs in  
13 Maryland is that it has hospital global budgets, and  
14 hospitals can relieve some pressure on their budgets by  
15 referring ambulatory surgeries to ASCs rather than HOPDs.

16 A final factor that we identified that could be  
17 slowing the shift of procedures from HOPDs to ASCs is that  
18 more physicians are choosing to be hospital employees and  
19 fewer are choosing private practice. This is a concern  
20 among stakeholders in the ASC industry.

21 From 2012 to 2022, the share of physicians  
22 working as employees increasing in 42 percent to 50

1 percent, while the share working in practices wholly owned  
2 by physicians declined from 60 percent to 47 percent. And  
3 as more physicians become hospital employees, fewer are  
4 available to provide the surgical procedures in  
5 freestanding ASCs. And this shift to hospital employment  
6 can limit the growth of ASCs.

7           And even though we said earlier that a shift to  
8 surgical procedures from HOPDs to ASCs could be beneficial  
9 to Medicare beneficiaries and providers, we do have a  
10 concern about such a shift, because data on ASC quality  
11 provide a limited assessment of ASC performance and  
12 surgical outcomes. Although the system has some measures  
13 on outcomes in some specialties such as GI, orthopedics,  
14 and urology, it lacks measures for important specialties  
15 such as ophthalmology and pain management.

16           Over the next few years, CMS will add 10 measures  
17 to the ASC quality reporting program, and this will allow  
18 for a more meaningful assessment of ASC quality. However,  
19 we would like to see more clinical outcomes measures, such  
20 as site of surgical infections and patient improvement  
21 after joint replacement.

22           The final point you would want to discuss is that

1 the structure of ASC ownership is changing. In 2021, 95  
2 percent of ASCs had some degree of physician ownership, but  
3 only 52 percent of ASCs were actually fully owned by  
4 physicians. Other ASCs had some ownership combinations,  
5 such as physicians with hospitals or physicians with  
6 corporate entities. This ownership of ASCs by corporate  
7 entities is increasing.

8           From 2017 to 2022, the share of ASCs that had  
9 some ownership by corporate entities increase from 18.6  
10 percent to 20.8 percent, and the ownership of ASC by  
11 corporate entities is expected to increase. For example,  
12 one of the large corporate holders of ASC has continued to  
13 acquire ASCs throughout 2023.

14           So for today's discussion, we will, of course,  
15 address Commissioners' questions and comments. We also  
16 welcome your thoughts on the benefits and drawbacks of  
17 surgical procedures migrating from HOPDs to ASCs.

18           And lastly, a question that Commissioners could  
19 consider is whether Medicare policy should be used to  
20 encourage procedures to migrate from HOPDs to ASCs.

21           That concludes the presentation. I turn it back  
22 to Mike.

1 DR. CHERNEW: Thanks, Dan. I know we have at  
2 least a few Round 1 questions, and I will ask mine after.

3 I think Brian is first in the Round 1 queue. Is  
4 that right, Dana?

5 DR. MILLER: Thank you. A very interesting  
6 chapter, which I enjoyed reading.

7 A few sort of technical questions. One is on  
8 page 2, we note that ASCs could be choosing to avoid rural  
9 areas and areas with high social risk factors because of a  
10 lack of profitable opportunities, which create issues of  
11 equity for beneficiaries in these areas. I think we should  
12 eliminate that sentence because we don't have clear  
13 evidence to support motive, and this also may be because --  
14 and we could consider adding this, that cause are serving  
15 this role, and therefore, there might not be a market need  
16 for ASCs.

17 The same assertion is made about corporate  
18 ownership for ASCs. So I have that same concern there.

19 On page 8, the ASC versus HOPDs, are we  
20 considering all HOPDs as the same facility, or are we  
21 talking only about those that offer ambulatory surgery?

22 DR. ZABINSKI: Those that offer ambulatory



1 surgery.

2 DR. MILLER: Okay.

3 And then I really liked the discussion on CON. I  
4 was wondering if on page 19, figure 1, if maybe adding to  
5 the table, ASCs per capita and comparing it with CON  
6 regulation of ASCs might further emphasize that point and  
7 make it clear. And the Mercatus Center has endless  
8 resources on certificate of need.

9 Thank you.

10 MS. KELLEY: Mike, did you want to go ahead?

11 DR. CHERNEW: Yeah. So here's my Round 1  
12 question. To what extent are ASCs different clinical  
13 things, like a hospital -- an inpatient hospital setting  
14 and a nursing home are different things, as opposed to just  
15 different fee schedules that something that's kind of  
16 similar chose. So I could look like -- I could be an HOPD,  
17 I could be an ASC, and whether I'm one or the other is less  
18 about what I am and more about which -- you know, if they  
19 change the rules, I could classify more things as ASCs.  
20 I'm not sure how much they're clinically different versus  
21 just fee schedule choices, if that makes sense.

22 DR. ZABINSKI: I would say from a -- and I'm

1 going to hope that clinical experts on the Commission  
2 correct me. I'm sort of guessing here that from a surgical  
3 -- ambulatory surgical viewpoint, that they're probably  
4 pretty similar in most respects. Of course, HOPDs offer a  
5 wider range of things. In particular, they are subject to  
6 EMTALA rules and regulations. So that's, I think, the  
7 biggest difference is that HOPDs have a much broader  
8 purpose in life than ASCs.

9 DR. CHERNEW: Amol.

10 DR. NAVATHE: Yeah. So I'll just add to what  
11 you're saying, Dan, a little bit. So I think it depends a  
12 little bit on your vantage point. If you're looking at --  
13 if you put on blinders, show up in an ASC or an HOPD that's  
14 doing a particular procedure, a cataract or a knee  
15 replacement, could you look around the room and say, "Wow.  
16 This looks totally different? I know I'm in an HOPD or  
17 ASC"? Probably not, right?

18 But if you didn't put on blinders and you walked  
19 into the HOPD OR versus an ASC, you would say, "Wow. I'm  
20 in a totally different place," and what's happening here at  
21 the facility clinically is very different than what's  
22 happening in an ASC.

1           So I think it's a little hard to answer your  
2 question from that perspective, just because it depends a  
3 little bit on what the -- how big our aperture is to make  
4 that decision around setting.

5           DR. ZABINSKI: Like even one personal -- this  
6 actually happened to me. Years ago, I broke my thumb in a  
7 very strange way, and I had to have a pin put in instead of  
8 a cast put on, and they put the pin in, in an HOPD, and it  
9 was super busy, emergencies all over the place. My surgery  
10 was delayed by hours, but once you get into the operating  
11 room, it's the same thing.

12           Then I've been in ASCs for a few other things,  
13 and once you're in the operating room, it seems really  
14 similar. But the before and after is very different.

15           DR. JAFFERY: Dan, when you say you broke your  
16 thumb in a strange way, do you mean that the break was  
17 strange or the manner in which you broke it was strange?

18           MR. MASI: Dan, don't answer that.

19           [Laughter.]

20           DR. ZABINSKI: Where it was broke. I broke it  
21 playing basketball, but I broke it on the first bone below  
22 the joint, right underneath my nail.

1 DR. JAFFERY: I'll have more on this in Round 2.

2 DR. ZABINSKI: Okay.

3 DR. MILLER: I have Round 2 basketball questions.

4 [Laughter.]

5 DR. CHERNEW: Yeah. I think we're actually at  
6 Round 2. Is that right?

7 MS. KELLEY: We are.

8 DR. CHERNEW: Yeah.

9 MS. KELLEY: And I have Cheryl first.

10 DR. DAMBERG: Thanks. Great chapter.

11 So first and foremost, I support continued  
12 recommendation on collecting cost data to try to better  
13 understand the cost structure of ASCs.

14 Secondly, I'm supportive of more robust quality  
15 measurements, particularly focused on outcomes.

16 I think one of the things that would be  
17 interesting to explore in this space is the volume outcome  
18 relationship, because I'm assuming with this amount of  
19 specialization, providers might get really good at what  
20 they're doing. So maybe there's fewer complications.

21 But counterbalanced by that, I think there's  
22 potentially sort of lurking this issue of inappropriate use

1 of services. So I think to the extent people are focused  
2 on developing performance measures, measures of  
3 appropriateness would be helpful.

4 And then two other comments. In terms of other  
5 entities owning ASCs, corporate entities, I think health  
6 plans have been moving fairly aggressively into the space,  
7 and we should acknowledge that.

8 And then, lastly, I am not sure I know to what  
9 extent MA plans are using ASCs, and is there anything to  
10 learn from looking at the MA space?

11 DR. ZABINSKI: I'm not sure to what extent, but I  
12 do know that, yeah, there is a tendency in MA to use ASCs  
13 more than fee-for-service.

14 DR. DAMBERG: And so with the profile, in terms  
15 of the set of services, or --

16 DR. ZABINSKI: I don't know that. I just sort of  
17 know that it's for the likelihood in MA to go to an ASC is  
18 greater than fee-for-service.

19 DR. DAMBERG: Thanks.

20 MS. KELLEY: Brian.

21 DR. MILLER: I love the story about basketball,  
22 and actually, your ASC versus hospital experience

1 emphasizes something I think we should emphasize more,  
2 which is that the beneficiary experience in ASCs is huge.

3 I've had surgery in a hospital, and it was -- I  
4 mean, they did a great job, but it was very slow, waited  
5 forever. I was starving. I became -- we all become  
6 hangry when we don't eat. Your surgery is scheduled at  
7 7:30, and it's delayed until 2:30 p.m., not the hospital's  
8 fault. But I think emphasizing the beneficiary experience,  
9 if you're 80 years old and you take 15 medications and you  
10 live at home and it's hard for you to get to your clinical  
11 appointment, let alone a procedure, the opportunity to have  
12 that done in a safe, efficient, and effective manner and  
13 get you out the door and back home sooner is a huge win.

14 I've had patients who have been admitted because  
15 they missed their heart failure meds, because their  
16 procedure took so long, and then they came out post op and  
17 had a heart failure exacerbation. This has happened during  
18 residency. I remember that specifically. So I think  
19 beneficiary experience is a huge win.

20 One other technical comment, before my other  
21 Round 2 comments, on table 5, the number of ASCs per Part B  
22 beneficiary, we should also probably add a table for HOPD

1 or a column for HOPDs that can do outpatient surgery to see  
2 if there's any differentiation.

3 I think another thing, which I expect Larry will  
4 mention, is small physician-owned practices. I view this  
5 as a -- in the small physician-owned practice bucket. So  
6 the loss to corporate consolidation is a concern to me from  
7 change from physician ownership to large companies.

8 I think the MA question that Cheryl brought up is  
9 really important because what MA plans may be doing, they  
10 may be using network design to steer people towards a focus  
11 factory that is higher quality and lower cost. So I think  
12 that we should definitely comment on that.

13 The quality thing, I agree that ASCs should  
14 report quality data in a similar fashion to HOPDs. So we  
15 should talk about equalizing quality regulation.

16 I'm cautious, though, because quality regulation  
17 in CMS has a very poor history of being very expensive, not  
18 necessarily meaningful to beneficiaries or the population.  
19 So I would see this maybe as slightly increasing quality  
20 burdens for ASCs while potentially decreasing quality  
21 reporting burdens for HOPDs, to put them on a more equal  
22 playing field.

1           And then I think the other question to ask about  
2 ASCs, if they aren't providing a cost and quality data to  
3 fee-for-service, are they somehow providing that  
4 information to MA plans through their negotiations?

5           MS. KELLEY: Robert.

6           DR. CHERRY: Yes, thank you.

7           So this is a great chapter, and I think the  
8 discussion has been teed up nicely.

9           I do agree that, as best as possible, we should  
10 try to migrate patients from hospital outpatient  
11 departments to ASCs, but it is very challenging. I  
12 wouldn't say that we can wave a magic wand and it would  
13 magically happen.

14           Many hospitals are already motivated to shift  
15 low-acuity surgical patients to ASCs to make room for more  
16 complex outpatient procedures that are in proximity to the  
17 main hospital, but that the challenges in doing that  
18 wholesale, even for patients that can be put into an ASC,  
19 is really operational and workflow-related, and much of it  
20 centers around geography.

21           So a lot of hospitals employ their surgeons, and  
22 those surgeons are also doing inpatient procedures, some of



1 them elective, some of them urgent, and so they need to be  
2 in proximity to the hospital. And for that reason,  
3 sometimes it just can't schedule the patient, you know, in  
4 an ASC at that particular time. They may also have  
5 conflicts with clinics or their office visits, or they may  
6 be on call or taking other types of inpatient round  
7 responsibilities that makes the ASCs difficult to get to or  
8 deploy to, which is one of the reasons why hospitals can't  
9 migrate those patients in its entirety.

10           The other thing too is that more and more  
11 surgeons are employed, as was mentioned, and therefore,  
12 there's even more limited availability to deploy to ASCs,  
13 particularly if those physicians are hospital-based. But  
14 for those ASCs that are physician-owned, they tend to have  
15 outpatient practices, anyway. So it's very easy for them  
16 to actually manage and not have to worry about the hospital  
17 environment.

18           And the other challenge for hospitals is that  
19 those that are corporate-owned, that the hospitals may not  
20 be in full control of access, or access may be limited by a  
21 contractual relationship that they may have with a  
22 corporate-owned entity.

1           I think that the bigger issue, to tell you the  
2 truth, when I think about ASCs, it is more the fact that  
3 some of these ASCs -- not all of them -- are outside of a  
4 rigorous regulatory environment, not necessarily those that  
5 are corporate-owned, not necessarily those that are  
6 physician-owned by large multidisciplinary surgical  
7 practices or hospitals that have joint ventures with  
8 others. But there are smaller ASCs out there that that  
9 don't have like rigorous regulatory oversight. To me,  
10 that's the bigger sort of safety and Medicare type of  
11 issue.

12           LeapFrog has actually been working on this for  
13 several years. They've been serving ASCs, trying to get an  
14 understanding of the regulatory landscape, how they're  
15 regulated, because many ASCs are regulated not in the same  
16 way as hospital outpatient departments. There is a lack of  
17 quality data.

18           I would just, Dan, encourage you actually to talk  
19 to LeapFrog as well, just to get a sense of what they have  
20 found over the last several years, looking at ASCs to kind  
21 of match it up with what you're looking at. It could help  
22 inform some of your thoughts for shaping future chapters on

1 this particular issue.

2 Thank you very much for the great work.

3 MS. KELLEY: Jonathan.

4 DR. JAFFERY: Thanks, Dana.

5 And so, Dan, thanks. This is a great chapter.

6 We've been talking about ASCs every year since I've been on  
7 the Commission. I feel like I learned a ton from this  
8 chapter, nonetheless, so great job.

9 I had two things. One is in the summary page,  
10 you talk about some of the advantages that ASCs have and  
11 allowing to perform more procedures and how that might earn  
12 more revenue -- allow providers more revenue, but I think  
13 building on some of the comments that Brian made about the  
14 experience, there's actually -- you know, I think the idea  
15 that somebody is in a procedure for less time or under  
16 anesthesia for less time is a clear advantage to the  
17 patient as well. So being able to do things more  
18 efficiently and quickly is a patient care improvement, if  
19 you will.

20 Another thing is just a little more  
21 philosophical. I'm struck by the juxtaposition between the  
22 conversation we're having now about ASCs and the

1 conversation we just had about Hospital at Home. So if we  
2 were -- if ASCs hadn't existed as a thing and then the  
3 pandemic came along and we said, oh, there's this place  
4 where people can go get procedures and that's going to help  
5 keep people out of the hospital, so we'll create a waiver  
6 and let them do that, we would have all the exact same  
7 issues that we just talked about, Hospital at Home, in  
8 terms of concern about decompensation, concern equity,  
9 which people have brought up some of those things. And so  
10 I just -- I think we need to be -- I think it's important  
11 that we have some consistency in our approach to things.

12           These are all opportunities to create innovation  
13 and move people to more efficient places that meet  
14 patients' needs better, in different ways, and it could be  
15 cheaper for providers and all the things that we think  
16 about -- and the Medicare program ultimately, but I think  
17 we want to -- we want to keep that in mind.

18           And in thinking about the broader topic about  
19 hospital outpatient ASCs, one of the reasons that people  
20 may for the same procedure -- this maybe goes back to  
21 Mike's Round 1 question a little bit -- for the same  
22 procedure be in one place versus the other is because we

1 have more concerns about their clinical condition and  
2 whether they might need that backup that exists in the  
3 broader ecosystem of a hospital environment.

4 DR. CHERNEW: So I just want to say two things in  
5 response to that, and both I agree about the analogy with  
6 ASCs and Hospital at Home, although I do think there's some  
7 important differences. One of them is, at least for now,  
8 ASCs are paid a fraction in some ways of what HOPDs are  
9 paid. Whereas, the Hospital at Home discussion is kind of  
10 treating the hospital home at the same rate. If we were  
11 having a discussion of should we have ASCs but pay them at  
12 the HOPD, right -- and so there's this -- in both cases, I  
13 think you're exactly right. The patients are not randomly  
14 drawn. You're not randomly taking someone from a hospital  
15 and putting them in a Hospital at Home. You're not  
16 randomly taking someone from an HOPD and putting them in  
17 ASC. You're picking selected -- Brian used the word, I  
18 think, right, focus factory kind of patients, which affects  
19 the payment, and it affects the spillovers between them,  
20 like what happens to the organization that's losing  
21 patients as some subset of patients gets siphoned away.

22 The Hospital at Home is also somewhat different

1 because unlike at least for now, in the hospital at home  
2 world, you basically have the actual hospital providing it  
3 at Hospital at Home. Whereas, the ASC world, I think, grew  
4 up in a world where you had people that were different  
5 organizations, different financing, different financial  
6 flows, building something out. We could have a world in  
7 which hospitals -- hospitals themselves could create an ASC  
8 entity that was sort of focused, and that could be an ASC,  
9 or it could be just a specialized HOPD in some conceptual  
10 way, which actually would be better for the hospital if  
11 they could get that in -- because the fee schedule  
12 differential. So I think there's a lot of similarities,  
13 but there are some nuances in how they've evolved  
14 differently.

15 DR. NAVATHE: I actually think there's a  
16 reasonable amount of variation, even in this -- like in the  
17 taxonomy that you described, there are hospital  
18 organizations that own ASCs.

19 DR. CHERNEW: Yeah.

20 DR. NAVATHE: There are hospitals that sort of  
21 transfer to Hospital at Home, but the staff is not the  
22 hospital staff. It's vendorized.

1           So I think there's a lot more blurring than -- it  
2 would be nice if it was all clean, clean, clean, but I  
3 think it's actually pretty blurry.

4           DR. CHERNEW: And some of it, I think, is blurred  
5 over time.

6           I want to make sure. I don't want to -- we have  
7 a few more people in the queue. I think there's a chance  
8 we're going to get to Round 3, and this is a perfect Round  
9 3 discussion. So as much as I want to engage in this  
10 conversation right -- with that faith, I can't say no.

11          DR. MILLER: May I --

12          DR. JAFFERY: The only -- what I heard as  
13 concerns in the last discussion were not about the finance  
14 primarily. It was about the safety and the equity, and so  
15 it was those things and totally fair that they're not  
16 perfect analogies.

17          DR. MILLER: May I make a comment on safety?

18          DR. CHERNEW: Let's go in order this time, and  
19 then we'll get to Round 3. So who's next?

20          MS. KELLEY: Amol is next.

21          DR. NAVATHE: Thank you.

22          Dan, fantastic work, really nice synthesis of an

1 ever-evolving topic. So I really appreciate your work  
2 here.

3 I actually have a Round 2 question, a Round 1  
4 question that didn't emerge until round 2. You have  
5 highlighted -- so what I'm kind of looking for in general  
6 is what is -- what do we have in terms of literature and  
7 evidence in this space around a quality patient experience?  
8 I think we've heard your anecdotal experience and other  
9 Commissioners' anecdotal experience of, hey, it was a lot  
10 better to go to an ANC. Anecdote, as we know, is not  
11 evidence. So I was curious. Do we have -- is there a  
12 literature around this?

13 We have a paragraph that says basically we need  
14 more quality measures, but there are some ASC quality  
15 measures. How well are they capturing patient experience  
16 if we really think that's where the benefit is? And I was  
17 curious if you could just give us a sense of what's out  
18 there, both in the peer- review literature as well as  
19 through CMS.

20 DR. ZABINSKI: Okay. The literature, I don't  
21 think there -- I haven't come across much. There was a  
22 study -- and it was actually quite a few years ago now --



1 about surgical site infections, the rates that they happen  
2 in ASCs. I don't think it was comparing to HOPDs at all.  
3 It was just discussing that it does occur. I don't think  
4 the rate was all that high.

5 CMS currently -- what CMS has been doing, they  
6 had a number of measures initially, and then they decided  
7 that, oh, a lot of them weren't all that useful. So they  
8 really paired back four, now they're up to six. Three of  
9 them are for hospital visit after a surgery. There's  
10 orthopedic, urology, and after a colonoscopy. One is on  
11 appropriate interval between colonoscopies for average risk  
12 patients. Another one is a patient have a normal body  
13 temperature within -- you know, like 15 minutes after  
14 getting out of anesthesia. What's the last one? I don't  
15 remember the sixth one offhand. Oh, right. It was after a  
16 cataract removal, did the patient have like an emergency  
17 removal of their vitreous from their eye? And that's the  
18 sixth.

19 DR. NAVATHE: I see. Okay. So thank you.  
20 That's super helpful.

21 So I think, in that sense, I guess I would echo  
22 Cheryl's points, and I think we've talked about this

1 previously, that it would be -- I would strongly support  
2 the recommendations that we've had around collecting the  
3 cost information as well as a broader assessment of  
4 quality, keeping in mind some of the administrative burden  
5 issues that Brian and others have brought up.

6           And then, lastly, I wanted to also just echo  
7 Jonathan's point, that I think we want some symmetry, I  
8 think, in how we approach these alternative settings. I  
9 think we should similarly -- not to be alarmists, but we  
10 should be similarly concerned about appropriate clinical  
11 management, especially in the context of Medicare  
12 beneficiaries. You can have unexpected decompensation, et  
13 cetera.

14           So I think we just want to have symmetry in how  
15 we approach all these different settings.

16           Thank you.

17           DR. CHERNEW: So I think we have Gina and then  
18 Larry, and then we're going to go to Round 3 to the extent  
19 that time exists. But the one thing I do know is we have  
20 Gina next.

21           MS. UPCHURCH: Thanks.

22           My experience in an ambulatory center was that I

1 had to stay overnight. So I'm not, you know -- and I'm  
2 reading the definition of it. They didn't ship me out, but  
3 this was a couple of years ago. So is that allowed, and is  
4 that becoming more and more common? Because then that --  
5 I'm just curious about that, and that probably was a Round  
6 1 question.

7           And the second one is the one thing that -- I  
8 don't deal with coding, but the one thing we hear in health  
9 care is the administrative burden of coding has just gotten  
10 way out of control. So I'm just -- I'm sensitive to asking  
11 for more coding. We need it. So do we have any say in  
12 simplifying coding for some of these issues that we're  
13 concerned about, whether it's ambulatory care surgical  
14 center or other? Do we have any comments on coding ever?

15           Thanks.

16           DR. ZABINSKI: On the overnight stay, I'm just  
17 shocked to hear that you would stay overnight, because it's  
18 supposed to be no, never happen, ever.

19           MS. UPCHURCH: Too much anesthesia.

20           DR. ZABINSKI: Too much anesthesia. Interesting.  
21 Okay.

22           And then on the coding, I'm not sure what to say

1 about that, and I'm assuming you need coding for what  
2 specifically?

3 MS. UPCHURCH: Well, if we're talking about cost  
4 reporting. I'm sorry. I should have said cost reporting -  
5 -

6 DR. ZABINSKI: Cost reporting.

7 MS. UPCHURCH: -- instead of coding. Cost  
8 reporting. But if we're asking them potentially to now  
9 start using -- sharing cost reporting and that's more  
10 administrative burden, which was a concern, do we have any  
11 say in simplifying that, or is that sort of a CMS form?  
12 I'm just curious.

13 Thanks.

14 DR. ZABINSKI: We -- I'm sorry. Go ahead.

15 MR. MASI: I'll try to jump in, but, Dan, you  
16 should jump into my jump-in.

17 I think at a high level, the Commission has often  
18 supported greater ease of -- easing administrative burden  
19 across things like quality measurement, reporting, things  
20 like that. I don't know that we have a narrow or specific  
21 footprint in this area of the type you're talking about but  
22 happy to take that back and see what we have.

1 DR. CHERNEW: There's a comment from Larry. Did  
2 he send --

3 MS. KELLEY: Yes, he did.

4 DR. CHERNEW: Okay.

5 MS. KELLEY: Larry has a question. Is there any  
6 evidence on the extent to which physicians in private  
7 practice use ASCs for their patients with high-paying  
8 insurance and HOPDs for their low-paying patients; for  
9 example, Medicaid and even perhaps Medicare?

10 DR. ZABINSKI: We don't typically include that  
11 information in our ASC chapters. But every year, I do  
12 collect information about the share of HOPD surgical  
13 patients and ASC surgical patients that are Medicaid. I  
14 think, if my recollection is right, it's about you're twice  
15 -- let' see. An HOPD surgical patient is twice as likely  
16 to be a Medicaid dual eligible as an ASC surgical patient,  
17 something of that magnitude. That's the most I have on it.

18 DR. CHERNEW: Some of that could be location  
19 stuff.

20 DR. ZABINSKI: Yes.

21 DR. CHERNEW: Okay. I think we're going to start  
22 Round 3, which is going to be -- we're getting to the end,

1 but we have Cheryl and Brian.

2 DR. DAMBERG: One thing I neglected to mention  
3 for this chapter, it might be helpful to add something  
4 related to the topic of consolidation.

5 So there's a fairly recent study by Chris Whaley  
6 and colleagues that showed that once providers consolidated  
7 into hospital and health systems, they were less likely to  
8 direct patients to ASCs. So kind of the market structure  
9 is affecting provider behavior in terms of their use of  
10 ASCs.

11 DR. CHERNEW: And just to be clear, they could  
12 have directed people to some entity that looks like an ASC  
13 but called it an HOPD. That's why there's this question  
14 about how much is a fee schedule and how much is an entity,  
15 because you can't be an HOPD if you're just an ASC. But if  
16 you're a health system, you could manage that potentially.  
17 I think that's my Round 3 answer to your Round 3 question.

18 DR. DAMBERG: Thanks.

19 DR. CHERNEW: Brian.

20 DR. MILLER: Lots of thoughts. So part of the  
21 reason that there might not be as many Medicare or Medicaid  
22 dual eligibles and private practices going to ASCs is

1 because there really aren't any private practices left in  
2 the country. So I think that's an important consideration.

3           The safety comment on Hospital at Home versus  
4 ASCs is not entirely accurate because at ASCs, you  
5 frequently have an anesthesiologist there. You have  
6 physician there, right there in person. If you have  
7 cardiac arrest or respiratory arrest, they can zap you, do  
8 CPR, and intubate you. You can't get that at Hospital at  
9 Home. It's up within maybe 30 minutes. So that's a very  
10 different emergency service access.

11           Cost burdens and quality reporting burdens,  
12 again, understand that I think people should have an equal  
13 quality regulation. I pointed out that there was a small  
14 business committee hearing on over-regulation in health  
15 care destroying small practices and small businesses  
16 earlier in the summer. So we should be very cognizant  
17 about increasing administrative burdens on small  
18 businesses, and an ASC is definitely a small business in  
19 the health care setting. I think an important thing for  
20 those that are independently owned.

21           Many taxpaying hospitals -- and I think we should  
22 use the language of "taxpaying" and "tax exempt" versus

1 non-profit or for-profit, because the antitrust community  
2 and economics literature shows that these organizations  
3 both behave the same way and try and maximize revenue. But  
4 I think that taxpaying hospitals have frequently vertically  
5 integrated into the ASC and outpatient space in order to  
6 put the patient or beneficiary at the right side of care,  
7 and so I think that we should acknowledge that in this  
8 chapter.

9 DR. CHERNEW: Okay. If I have this right, Dana,  
10 we're at the end.

11 So I will make some wrap-up comments, but just so  
12 I don't forget, for those of you at home, if you want to  
13 reach us and give us your thoughts on these topics, please  
14 send your comments to [MeetingComments@medpac.gov](mailto:MeetingComments@medpac.gov),  
15 medpac.gov, or otherwise, reach out to us on the website,  
16 and we are very interested.

17 Dan, as always, outstanding job. We do -- I  
18 think Jonathan kicked us off by saying this is just a  
19 perpetual topic.

20 I will just close sort of by broadly saying --  
21 I'll try and stick on the theme that we were talking about,  
22 Jonathan, about the analogy with Hospital at Home or not.



1           There's different problems that we face, and I  
2 think there's always this question about what problem we're  
3 trying to solve. So the first thing, let me say in this  
4 chapter, we're actually not trying to solve a problem.  
5 This is an ASC status report. It is what's going on in  
6 ASCs. There are times when we have specific issues about  
7 trying to solve problems potentially with ASCs, but I think  
8 in the broadest sense -- and I think certainly this morning  
9 in both sessions that we've realized -- there is great  
10 interest in making sure that patients go to the setting  
11 that is best suited for them, which means safe, efficient,  
12 high-quality care.

13           And there's a number of patients that can get  
14 that type of care in settings that they might not just  
15 historically have gotten it in -- that could be Hospital at  
16 Home; it could be an ASC -- in a range of ways.

17           I think there's two challenges that we face when  
18 we think through that. One of them is just if you're  
19 siphoning patients from one setting to another, but they're  
20 not randomly selected, what should the payment rate be for  
21 those set of patients in that other setting? We have an  
22 existing differential for ASCs. We don't potentially for

1 Hospital at Home. ASC is just a longer, more established  
2 set of things.

3           The second thing that I think is actually  
4 important and we have a really hard time grappling with is,  
5 what does it mean for the setting that's left behind? So  
6 when we pay the organizations that's left with all the  
7 patients that were actually not suited for the other  
8 setting, what happens? And that became a big issue when we  
9 did our site-neutral stuff, for example.

10           We were very worried about how that would play  
11 out in the site-neutral discussion, and we will continue to  
12 be worried there, because I don't think it's the case that  
13 you take everybody in HOPD and set up some focused factory  
14 for them and say, "Okay. Let's just do it."

15           That doesn't mean we shouldn't do it for the ones  
16 that we can, right? It's just we have to think through  
17 what happens as technology enables us to move patients into  
18 different settings. They're connected in a range of ways,  
19 some more so than others.

20           And I guess the last thing I would be remiss to  
21 say, it's certainly true in the ASC space -- it may at some  
22 point be more true than I perceive it now in the Hospital

1 at Home case. It might be -- which is just sort of the  
2 broad organizational, consolidation issues. What types of  
3 pricing issues is that surfacing? What type of other anti-  
4 competitive or not issues is that happening when we have  
5 different types of organizations and financing schemes  
6 moving into one sector or another?

7 I think one challenge we have in the system is  
8 that the system is complex, and actually, I'm an economist.  
9 So I won't claim to know this, but the human body is  
10 complex. And we have a lot of parts, and they all seem to  
11 be subject to something bad happening. And there's  
12 different costs of making those things get better as best  
13 we can, and when we're all in one setting, it kind of just  
14 gets all lumped together, and it's sort of implicit in  
15 other cross-subsidies. When we begin to peel off things  
16 that we can now do technically for subsets of things, that  
17 actually can offer great power, but that breaking of the  
18 cross-subsidy system in a whole range of ways ends up being  
19 challenging to have us respond holistically to what's  
20 happening as opposed to focusing on the narrow thing. And  
21 I think ASCs illustrate that sort of general system  
22 challenge really well.

1           So again, for now, we are just at a status  
2 report. This will show up in the materials, and, Dan,  
3 you've done an outstanding job. We will continue to  
4 monitor, but more importantly, we will continue to think  
5 about the issues that all of this material raises. And  
6 when we get a chance and we can figure out what we might  
7 want to do, we may come back where we will really have a  
8 problem we're trying to solve as opposed to a status we're  
9 trying to report.

10           So anyway, that's where I am. I said -- I'll say  
11 again, MeetingComments@medpac.gov. I thank all of the  
12 Commissioners for your comments. I thank all of the staff  
13 for all of your work. Paul, thank you for getting through  
14 your first meeting. You have an infinite number more.

15           [Laughter.]

16           DR. CHERNEW: But that is a good way to start.  
17 Paul, do you want to add anything?

18           MR. MASI: No. Good show.

19           DR. CHERNEW: That could be our tagline: "Good  
20 show." Be safe out there. Okay. Bye. Thanks,  
21 everyone.

22           [Whereupon, at 11:32 a.m., the meeting was

1 adjourned.]

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